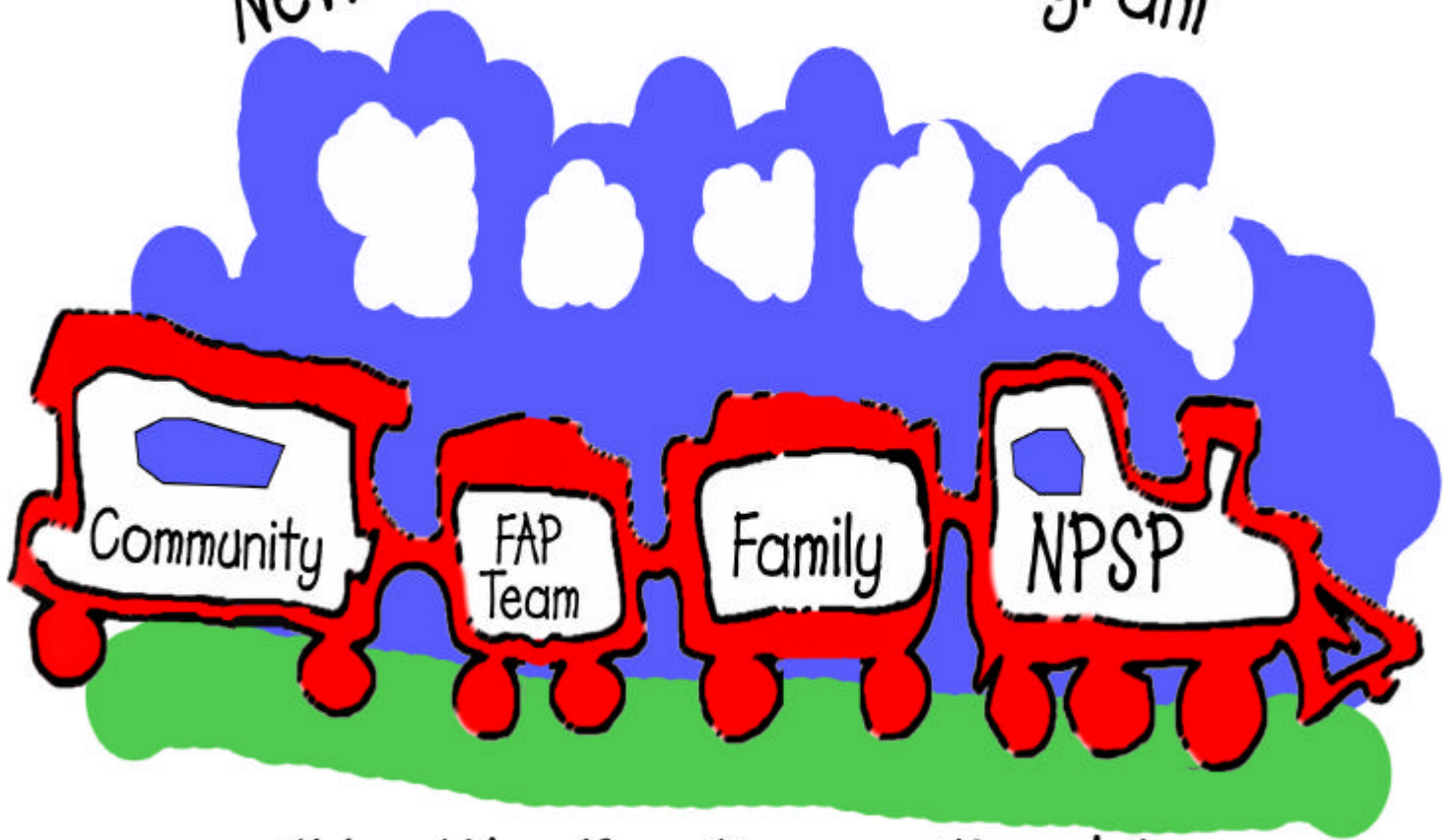


New Parent Support Program



"Healthy Families on Track"

PROGRAM MANUAL 1999

AIR FORCE FAMILY ADVOCACY
AFMOA/SGOF
OFFICE OF THE SURGEON GENERAL

NEW PARENT SUPPORT PROGRAM MANUAL

TABLE OF CONTENTS

Chapter I. Introduction/Overview	I-1
• FAP Mission	I-1
• Historical Perspective of Family Advocacy Prevention Programs	I-1
• AF Family Advocacy Program Home Visit Prevention Program	I-2
• The Literature and Home Visit Programs	I-3
Chapter II. New Directions in Prevention	II-1
• Overview	II-1
• Community	II-2
• FAP Prevention Program Elements	II-2
• Teamwork	II-4
• Linking Community Resilience and the NPSP	II-5
Chapter III. New Parent Support Program Overview	III-1
• DoD Model for New Parent Support Program	III-1
• DoD NPSP Services	III-1
• Development of the Air Force New Parent Support Logic Model	III-2
• Redesign of NPSP AF Model	III-2
• Outcome-Based NPSP Logic Model	III-3
Chapter IV. New Parent Support Program Operations	IV-1
A. NPSP – A Voluntary Universal Program	IV-1
• NPSP Community Services	IV-1
• Comprehensive NPSP Assessment	IV-2
B. Marketing NPSP	IV-4
C. Developing Community Services for the NPSP	IV-8
• The Role of Community Services in the NPSP	IV-8
• Steps In Developing Community Services for the NPSP	IV-10
• Minimum Requirements for NPSP Services	IV-12
D. Enter into The NPSP	IV-16
• Narrative for NPSP Flow Chart	IV-16
• NPSP Team Case Staffing	IV-21
• Developing A Family Service Plan (FSP)	IV-22

E. Ongoing Intensive Services	IV-24
• Closure Criteria	IV-24
F. NPSP Documentation and Data collection Processes	IV-26
1. Overview	IV-26
2. Documentation of Participant Services	IV-27
• Family Information Form	IV-32
• NPSP How Can We Help? Form	IV-33
• NPSP Contact Form	IV-35
• Family Advocacy Informed Consent-Prevention	IV-36
• NPSP Case Staffing Form	IV-42
• NPSP Family Service Plan (FSP) Form	IV-45
3. The Secondary Prevention Record - NPSP	IV-47
4. Data Collection Processes	IV-48
• NPSP Data Summary Form	IV-50
• NPSP Staff Daily Activity Form	IV-54
• NPSP Monthly Report Form	IV-59
G. NPSP Measurement Tools Instructions	IV-61
1. The NPSP Family Needs Screener	IV-61
• Summary of Decision rules for Measures and Home Visits	IV-63
2. Questionnaires to Use during Home Visits	IV-65
3. Description of Required Care Measures	IV-70
• HOME	IV-70
• Parenting Index (PSI)	IV-71
• Ages and Stages Questionnaire (ASQ)	IV-73
4. Description of Additional Measures	IV-74
• “Mood Inventory” (CES-D)	IV-74
• Resolving Couple Conflict Scale (CTS)	IV-75
• Resolving Parent-Child Conflict (CTS-PC)	IV-76
• Drinking Habits Inventory (“S-MAST”)	IV-77
• Index of Marital Satisfaction (IMS)	IV-79
H. Engaging Apparent “High Needs” Reluctant Participants	IV-80
I. Engaging Fathers	IV-85

Chapter V. FAP Team Roles in New Parent Support	V-1
A. NPSP Role of the Family Advocacy Officer	V-3
B. NPSP Role of the Family Advocacy Nurse	V-5
C. NPSP Role of the Family Advocacy Treatment Manager	V-35
D. NPSP Role of the Family Advocacy Outreach Manager	V-55
E. NPSP Role of the Family Advocacy Program Assistant/Technician	V-64
Chapter VI. NPSP Resources	VI-1
A. FAP NPSP Web Site	VI-1
B. Educational Resources	VI-1
C. Couples Communication	VI-7
Appendices	
A. GLOSSARY	
B. STANDARDS	
C. FAMILY NEEDS SCREENER TOOL DEVELOPMENT	
D. GETTING STARTED: A WORD FOR NEW NPSP STAFF	
E. NPSP SAMPLE RESOURCES	
F. SAMPLE OI	
G. MARKETING THE NEW PARENT SUPPORT TEAM	
H. NPSP FORMS	
I. NPSP ASSESSMENT TOOLS	

New Parent Support Program Manual Contributors

The following individuals contributed to the development of the New Parent Support Model and this manual. Without their attention, support, time and dedication, this project could not have been completed. Our sincere thanks to all.

New Parent Support Working Group

Donald Alexander, Offutt AFB Family Advocacy Program Assistant
Debbie Allen, Family Lackland AFB Family Advocacy Outreach Manager
Warren Bryars, Eglin AFB Family Advocacy Outreach Manager
Joni Darnell, Tinker AFB Family Advocacy Treatment Manager
Kathy English, Randolph AFB Family Advocacy Outreach Manager
David Hamilton, Randolph AFB Family Advocacy Treatment Manager
Cynthia Kenyon, Eglin AFB Family Advocacy Nurse
Verna Loosli, Elmendorf AFB Family Advocacy Treatment Manager
Kathy Milligan, Little Rock AFB Family Advocacy Treatment Manager
Capt Al Ozanian, Lackland AFB Family Advocacy Officer
Marcia O'Quinn, Seymour Johnson AFB Family Advocacy Nurse
SRA Kim Mitchell, New Parent Support Customer
Billi Moultrie, Patrick AFB Family Advocacy Nurse
Capt Franklin Swayne, Wright Patterson AFB Family Advocacy Officer
Angela Stevenson, Ellsworth AFB Family Advocacy Program Assistant
Glenda Taylor, Hurlbert Field Family Advocacy Nurse
Suzie White, Ramstein AFB Family Advocacy Program Assistant

AFMOA Family Advocacy Program Staff

Col John Nelson, AF Family Advocacy Program Manager
Lt Col Carla Monroe-Posey, Director of Research
Martha Salas, Nursing Program Manager
Pam Collins, Treatment Program Manager
Bettye Williams, Outreach/Prevention Program Manager
Les Besetsny, Research Program Manager
Cynthia Spells, USDA/FAP Liaison
George Fetterman, Chief, Administration
Fidencio Gonzales, Administrative Assistant
William Smith, Administrative Assistant
Kay Webber, Administrative Assistant

Program Evaluation Consultants

Glenda Kaufman Kantor, University of New Hampshire Family Research Lab
John Landsverk, San Diego Children's Hospital

CHAPTER I

INTRODUCTION/OVERVIEW

Air Force Family Advocacy Program Mission

The Mission of the AF Family Advocacy Program is to prevent family maltreatment and to identify and treat families where maltreatment has occurred. The FAP provides a continuum of services that include treatment for spouse and child abuse and a wide range of programs that are focused on the prevention of family violence.

Family violence is not congruent with Air Force standards and quality of life in the military. While violence in families can affect both the physical and psychological health of families, it reduces mission readiness if it impacts the ability of the active duty service member to focus on performance. As a result of the incidents of child abuse in the military, the Air Force recognized that programs and services were required to respond to this problem (Mollerstrom, Patchner and Milner, 1995).

In 1997 the Air Force abuse rate was 6.07 incidents per 1,000 children, compared with the civilian child abuse rate of 15 per 1,000 (U.S Department of Health and Human Services, Childrens Bureau, 1996). Severity of child abuse in the Air Force has consistently decreased since fiscal year 1994. Thus, the volume of our substantiated cases is decreasing and their severity is declining. We are confident the decreasing trend in severity will continue with our wide range of prevention programs and earlier identification and reporting of child and spouse maltreatment cases.

Historical Perspective of Air Force Family Advocacy Prevention Programs

In 1986 the Air Force FAP made a commitment to design, implement and support a primary and secondary outreach prevention program component targeting families at risk for abuse, with the specific goal of reducing intrafamilial violence. This prevention focus started with strategically placed outreach programs at most Air Force bases. The purpose of this initiative was to create a proactive outreach approach of early intervention before abuse occurred. The program was staffed by Air Force social workers, called Outreach Workers. Their role consisted of assessing community needs, developing prevention service plans, marketing Family Advocacy program services, planning and coordinating key prevention initiatives, developing community partnerships, and enhancing Air Force community protective factors through activities that heighten awareness of abuse. Prevention efforts by Outreach Workers were highly successful and well integrated in the FAPs across the Air Force. Their role became a core component of prevention programs.

CHAPTER II

NEW DIRECTIONS IN PREVENTION

Overview

The Air Force has had a long history of providing services to families with the goal of reducing the incidence of family maltreatment. As referenced earlier, the tradition began with a focus on direct service using a treatment approach. This system served the Air Force well. In 1986 the Outreach Program was established and designed to address prevention, providing a way to reach a broader range of families and to facilitate early intervention before an incident of maltreatment occurred. The FAP nurse was added with the introduction of the First Time Parents (FTP) program focused on home visitation. Later, a social worker and nurse team were added to implement Homebased Opportunities Make Everyone Successful (H.O.M.E.S.) as a home visitation pilot program to support families at high risk for maltreatment.

While our first efforts should focus on prevention, we know that there will likely always be families who will need more individual attention. The next step then, is to bring these outreach, prevention and maltreatment intervention services together in partnership.

A New Direction in Prevention requires that we weave prevention into the fabric of FAP as a natural, integral and necessary approach in service delivery to families. In providing support to families, our ultimate goal is to foster environments that promote and facilitate opportunities for forging connections. Not only must we think healthy families...but healthy communities. Our prevention efforts must address the secondary clinical needs of program participants, and at the same time we must take a broad-based approach in primary prevention.

A focus on macro-system intervention is a way to begin with the end in mind...to look at the big picture and then collaborate with the community to identify the desired outcome...building community resilience. To bring accountability to prevention we must utilize structured and research-based methods to map out our strategies and processes, and to assess risk and protective factors that inform program and service planning. Logic models, family and community assessment tools are essential to this process. Understanding prevention and community concepts and the importance of program evaluation is a way of getting started.

The refocus of the Outreach Program, with the publication of the *Outreach Manager's Guide* and the revision of the New Parent Support Program (formerly FTP) provide the catalyst for exploring new dimensions and moving toward new directions in prevention. The Family Advocacy Program's *New Directions in Prevention* support the Air Force Surgeon General's fourth pillar...building healthy communities. In this section we will define key community concepts, identify FAP community program elements, and discuss the importance of teamwork.

CHAPTER III

AIR FORCE NEW PARENT SUPPORT PROGRAM (NPSP) OVERVIEW

DoD Model for New Parent Support Program

Programs to support new parents contribute to mission readiness, support family adaptation to military life and are designed to enhance the knowledge and skills families need to form a healthy safe, nurturing environment.

Since military families are often separated geographically from their families of origin and civilian peers who are now parents, they may lack frequent physical access to hometown social supports and parental models. The Military Services have developed programs to support new parents during this critical lifespan period. The NPSP for new parents provides improved quality of life for service members and their families. The Services promote universal availability to increase participation.

In 1996, a joint–Service working group reviewed Service implementation of NPSP, developed a DoD NPSP model and provided recommendations to standardized the programs across all Services. The work of this group established a framework and parameters for the redesign of the Air Force NPSP.

The DoD model

- consists of services available to all new parents, (a universal program),
- requires screening of prospective participants for the purpose of identifying populations at-risk for maltreatment and,
- features intense home visiting-based services to parents at-risk for maltreatment.

While the working group recognized the need for variety and flexibility in programs to accommodate the unique requirements of each Service and installation, it recognized that a DoD framework is necessary to facilitate fiscal planning, evaluation, training and equity across Services. In particular the working group viewed a comprehensive DoD framework of services for new parents as a useful step in ensuring optimum use of resources, and promoting consistency in concept and range of services offered and efficiency in service delivery. The working group identified the range of services offered new parents and developed a standardized New Parent Support program model for DoD with different levels of intervention.

DoD NPSP Services

The range of New Parent Support services include “*standard*” services coordinating existing parenting programs available on military installations and from nearby civilian agencies. The services are educational, with information and referral to military and civilian agencies that can support new parents.

At the next level, the DoD framework requires that a screening process be to identify families where additional health and social support is needed. Based on the experience of civilian home visiting programs, the working group estimated that 18 to 20 % of the focus population of families with children aged birth to three years or pregnant spouses would be identified as “at risk” for maltreatment.

The DoD New Parent Support Program model requires assessment of young families screened to be at risk of maltreatment to receive a more intensive level of service, including ongoing home visits. In the Air Force, these “high needs” families may receive service from nurses, social workers, and paraprofessionals.

Development of the Air Force New Parent Support Logic Model

Healthy People 2000 has identified the reduction of injuries due to violence as a major public health goal. Former Surgeon General C. Everett Koop stated that domestic violence is " an overwhelming moral, economic, and public health burden that our society can no longer bear". The Center for Disease Control and Prevention has identified child maltreatment as a critical public health problem that is in need of and amenable to prevention approaches. Researcher Mercy and colleagues identified a critical need for programs that target children at risk early in life. Research has shown most offenders who shake babies didn't realize they were harming them critically but were simply frustrated with the crying and simply reacted impulsively (Bruce, 1989. Caffey,1972. Crowe,1992. Milner, 1995. Showers, 1992. Tyson, 1994). According to Olds and Henderson (1989) no single causal factor can explain maltreatment; instead it is a series of events like family history of abuse, child's temperament, quality of parents social supports, financial problems, and marital conflict.

If maltreatment is a symptom of family dysfunction, then our task is to recognize the difficulties facing the family as well as their strengths in order to intervene effectively. Pregnancy and parenthood represent major milestones for both men and women. Information, support and peer social connections provided during this window of opportunity seems crucial.

Redesign of NPSP AF Model

The AF Family Advocacy Program embarked on the task of redesigning the NPSP to:

- Realign with the DoD NPSP guidelines
- Improve services to customers by offering a universal NPSP
- Develop a consistent, evidence-based practice, quality program across all installations
- Evaluate current Air Force NPSP prevention services.

To facilitate this initiative, we partnered with the University of New Hampshire Family Research Lab to in the redesign and evaluation of FAP prevention services.

A multidisciplinary working group composed of Family Advocacy Officers, nurses, outreach managers, Treatment managers, assistants, and an NPSP customer were selected

to redesign the NPSP. This team worked for more than a year to produce a new NPSP product that offers universal NPSP services to all families of Active Duty members having pregnant spouses or children aged birth to three years. The new program facilitates a FAP team approach and involves an outcome based best practice model.

The goals of this working group was to redesign the current AF NPSP model to meet the following criteria:

- Meet DoD NPSP Model recommendations
- NPSP Universal Model for all AF families providing
 - Community prevention education and support programs for “high needs” families
 - Intensive home-based service
 - A total FAP Team effort in the AF NPSP Model
 - An outcome based service model
 - Research based best practice NPSP interventions
 - NPSP standardization across all AF bases

The working group developed the AF NPSP Model and drafted the manual and data forms.

Outcome-Based NPSP Logic Model

Logic Models are graphic diagrams that can be used to identify program goals, objectives, and interventions that are linked to program outcomes. In the NPSP, outcomes are ultimately focused on the prevention of child and spouse maltreatment. All program activities or interventions need to be linked to this outcome.

As you develop program and practice activities, you need to consider the linkages between program abuse prevention activities and outcomes. Examples of prevention activities linked to child maltreatment are education on :

- Prevention of Shaken Baby Syndrome
- Child developmental milestones for toddlers as they enter the potty training phase
- Problem-solving skill development for parents
- Role adaptation to a new child in family
- Positive parenting skills
- Communication skills

Another important use of a logic model is that it provides a framework for the practitioner to use in delivering services and evaluating results to determine if services are linked to the desired program outcome of preventing child and spouse maltreatment

NPSP Logic Model Components

Logic models components also help you see how services you provide fit with the program model. They also allow you to identify the focus population to be served, plan NPSP activities and meet the program goals, objectives, interventions, expected outcomes, thus linking NPSP components to the program outcomes. Further, logic

models help you determine which factors need to be assessed to determine if participants are benefiting from your program. NPSP program goals are to:

- Decrease potential for family maltreatment,
- Enhance parent role adaptation,
- Increase problem solving skills, and
- Increase knowledge of child growth and development.

Figure 1
New Parent Support Program- Logic Model

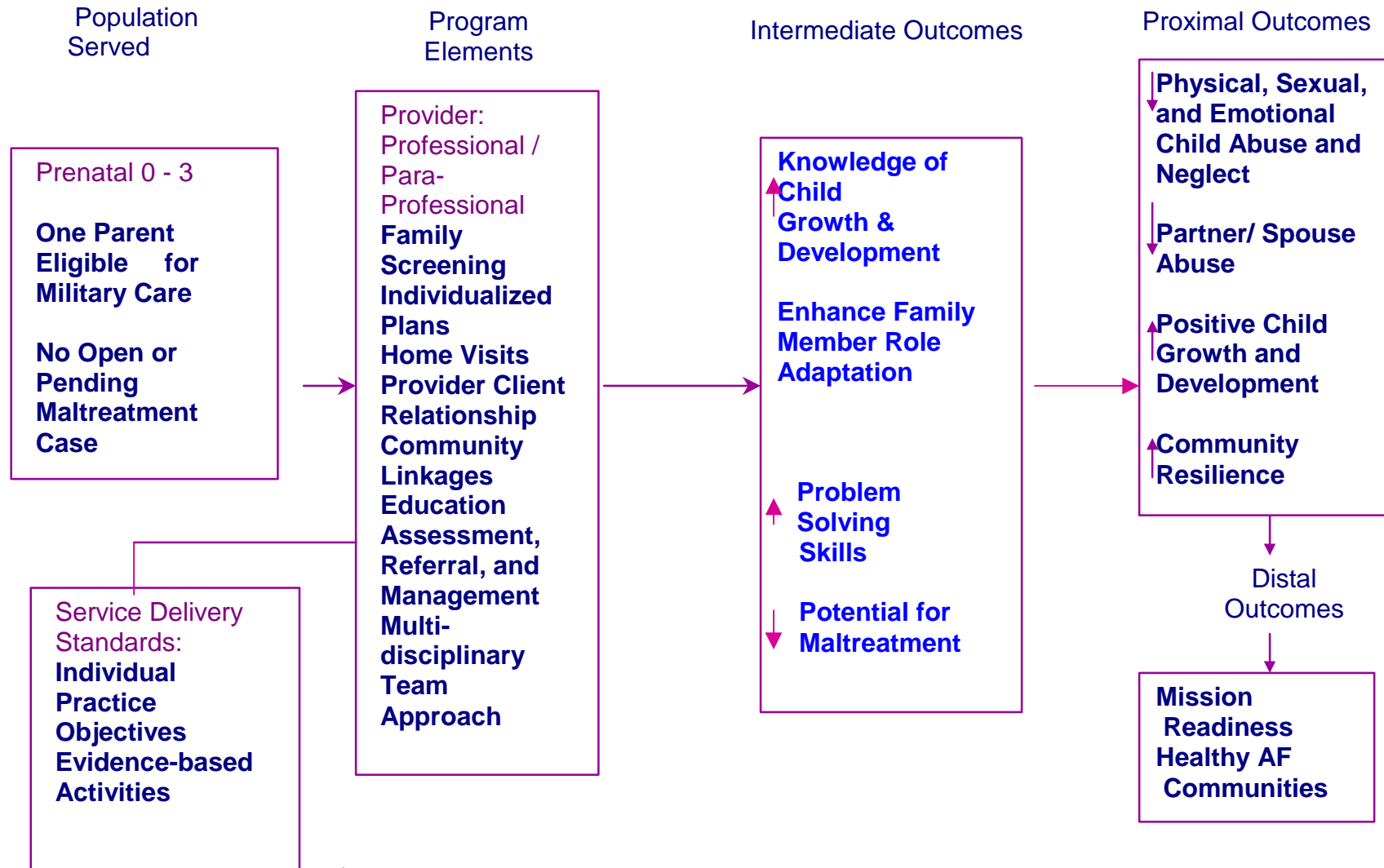


Figure 1 is the logic model that was developed for the New Parent Support Program by the USAF FAP NPSP working group.

Program logic models provide structure for organizing services that focus on a systematic framework for the purpose of evaluating intervention strategies, and guiding practice and program activities. Model components consist of the following:

- Focus Population
- Program Elements/Components
- Service Delivery Standards
- Outcomes:
 - Intermediate
 - Proximal
 - Distal

NPSP Focus Population

The focus population is defined as a group of individuals who are served for the purpose of providing NPSP interventions to prevent child and spouse abuse. The NPSP focus population are Air Force active duty families expecting a child or having children up to three years of age.

Program Elements

Program elements are linked to NPSP outcomes and identify more specifically who provides the service or intervention, and how they are delivered. Providers can be professional or para-professional FAP staff and interventions are delivered via home visits, groups or classes driven by participant need.

Good program planning should be based on solid research evidence. The results of past research studies provide a rationale for the components of the program model and the linkages between the components. For example, findings based on research on several home visitation programs indicate that providing education and linking families with formal and informal supports reduce maltreatment risk (Chalk and King, 1998; Guterman, 1997; Olds et al, 1995). Some intensive home visitation programs have demonstrated prolonged improvements in the life course of program mothers and their children in areas such as health and social functioning. Studies such as these provided the basis for the NPSP Logic Model and are summarized in **Table 1** below.

Table 1
Research Evidence for the NPSP Logic Model

Component	Definition	References
Program Elements <ul style="list-style-type: none"> Professional/para professional providers Multi-disciplinary team approach Provider/participant relationship Home visits Family screening Education 	<p>Both professionals (usually nurses) and para-professionals have been providers of services for high-risk families.</p> <p>In order for a home-visiting program to be effective, there must be rapport between the participant and provider, and the participant must perceive a need for the support. If this rapport does not exist, it can actually make mothers worse off than they were before the program started.</p> <p>Home visiting has been demonstrated to substantially decrease risk of child maltreatment.</p> <p>Families may be at risk due to demographic factors such as adolescent parents, unwed marital status, and low Social Economic Status.</p> <p>Families may also be identified using a family-stress approach. Families are screened for substance abuse and family violence history, as well as current family stress.</p> <p>Parent education has had a significant effect on parents' understanding of child behavior and child temperament. Further, improved parent competence reduced child neglect.</p>	<p>(Guterman, 1997; Hiarr, Sampson, & Baird, 1997; Olds & Kitzman, 1993)</p> <p>(Affleck et al., 1989)</p> <p>(Chalk & King, 1998; Kitzman et al., 1997; Olds et al., 1998)</p> <p>(Olds et al., 1997)</p> <p>(Gray et al., 1979)</p> <p>(Alvy, 1994; Cedar & Levant, 1991; Barth et al., 1988; Chalk & King, 1998)</p>

<ul style="list-style-type: none"> • Community linkages 	<p>Abusive parents are often socially isolated, with poor work histories and few friends. Breaking this isolation can be difficult but is important in decreasing risk of child maltreatment.</p>	<p>(Olds & Henderson, 1989; Polonsky, et al., 1985)</p>
<ul style="list-style-type: none"> • Assessment, referral and management 	<p>When parents are coached in parent-child interaction, and helped with basic life skills such as health and nutrition, home safety, counseling, job finding, and offered referrals for treatment of substance abuse, there were decreased rates of child abuse and neglect.</p>	<p>(Lutzker et al., 1984; Wesch & Lutzker, 1991)</p>
<ul style="list-style-type: none"> • Family-specific plans 		<p>(Berg, 1994. Jongsma & Peterson, 1995. Kumpfer & Alvarado, 1997.)</p>

NPSP Service Delivery

Service delivery standards are also evidence-based and linked to provider delivery practice. The NPSP model requires integration of practice and research so that participants receive best practice interventions that are standardized across all bases. Service duration and intensity are important factors influencing positive outcomes in NPSP families.

Families participating in the NPSP who have been assessed as having high needs and accepted home visits will receive a minimum of one home visit per month.

Although families may have varying needs for services, frequency of interventions can vary but should to be comprehensive in focus. Other key service delivery features affecting program outcomes include frequency of services by professionals and skills of service providers, and level of risk in participant families. For details on comprehensive NPSP interventions by the FAP team, see the Chapter V on team roles.

NPSP Outcomes

NPSP outcomes reflect goals of the NPSP as specified in the Logic Model and need to be measurable for both the program goals and individual practice activities. NPSP Logic Model outcomes are measured at three levels which are:

- **Intermediate Outcomes (anticipated changes in participants as they complete the program)**
 - Increase knowledge of child growth and development.
 - Enhance family member role adaptation.
 - Increase problem solving skills
 - Decrease potential for family maltreatment.
- **Proximal Outcomes (anticipated short-term post-program changes in participants, their families and the community)**
 - Decrease physical, sexual and emotional child abuse and neglect
 - Decrease partner/spouse abuse
 - Increase positive child growth and development
 - Increase community resilience
- **Distal Outcomes (anticipated long-term post-program changes in participants, their families and the community)**
 - Healthy AF Communities
 - Mission Readiness

NPSP services and activities should be linked with program service delivery standards, program elements, and program and practice outcomes. For example, the home visit, referral and linkage to local resources and improvements in couple communication may meet the goal of “decreased isolation.” See **Table 2** for additional outcome examples.

Activities with no clear link to NPSP outcomes should be considered carefully as to whether they contribute to NPSP goal attainment. For example, teaching Lamaze classes may be helpful to portions of the focus population, but the provision of this service by NPSP staff likely reflects a poor use of resources if it limits the availability of home-based services.

Some activities and conditions may affect outcomes independently or in combination with others. Multiple interventions and activities may create a synergistic impact and can be more effective than individual interventions alone.

Table 2
Research Evidence for the NPSP Logic Model

Component	Definition	References
<u>Intermediate Outcomes</u> <ul style="list-style-type: none"> Increased knowledge of child growth and development Enhanced family member role adaptation Increased problem-solving skills Decreased potential for maltreatment 	<p>This has been the outcome of several intervention programs focusing on the needs of parents of young children.</p> <p>Families participating in intervention programs showed decreased stress levels, decreased social isolation, and increased problem solving and increased parental competence. All of these factors decreased the potential for child maltreatment.</p>	<p>(Alvy, 1994; Barth et al., 1988; Lifur-Bennett, 1982)</p> <p>(Alvy, 1994; McBride, 1991; Thompson et al., 1993; 1998)</p>
<u>Proximal Outcomes</u> <ul style="list-style-type: none"> Decreased child maltreatment Decreased partner/spouse abuse Increased positive child growth and development Increased community resilience 	<p>Home visiting and parent education programs do reduce rates of child maltreatment.</p> <p>“Marriage enrichment” types of programs have increased marriage satisfaction and decreased levels of violence.</p> <p>“Effective parent” programs increase positive parent/child interactions.</p> <p>Enhanced community resilience and cohesion are linked to reductions in maltreatment rates.</p>	<p>(Olds et al, 1997; Olds et al., 1998;</p> <p>Chalk & King, 1998; Wesch & Lutzker, 1991)</p> <p>(Markman et al., 1993) (Alvy, 1994; Cedar & Levant, 1991)</p> <p>(Garbarino, 1995)</p>

<p>Distal Outcomes</p> <ul style="list-style-type: none"> Enhanced mission readiness Enhanced health of communities 	<p>Percent of early returns from deployments are for family problems.</p> <p>Adverse childhood events, such as child and spouse maltreatment and parental substance abuse, significantly affect adult health and well-being, and the health of our communities.</p>	<p>(Bell, Stevens, 1996)</p> <p>(Anda, 1999)</p>
--	---	--

REFERENCES

Affleck, G., Tennen, H., Rowe, J., Roscher, B., & Walker, L. (1989). Effects of formal support on mothers' adaptation to the hospital-to-home transition of high-risk infants: The benefits and costs of helping. *Child Development*, 60, 488-501.

Anda, R. (May, 1999). Presentation at the USAF Surgeon General's World-wide Prevention Conference.

Alvy, K.T. (1994). *Parent training today*. Studio City, CA: Center for the improvement of child caring.

Barth, R.P., Hacking, S., & Ash, J.R. (1988). Preventing child abuse: An experimental evaluation of the Child Parent Enrichment Project. *Journal of Primary Prevention*, 8, 201-217.

Bell, B., Stevens, M., (1996). How to support family during overseas deployments: A sourcebook for service providers. US Army Research Institute for the Behavioral and Social Sciences Research Report 1687.

Berg, I. (1994). Family-based services, a solution focused approach. Chapter 1, 1-16.

Bruce, D., & Zimmerman, R., (Aug. 1989). Shaken impact syndrome. *Pediatric Annals* 18:8

Caffey, J. (1972). On the Theory and Practice of Shaking Infants. *Am Journal of Diseases of Children*. 124:2.

Cedar, B., & Levant, R.F. (1991). A meta-analysis of the effects of parent effectiveness. *American Journal of Family Therapy*, 18, 373-384.

Chalk, R. & King, P (1998). *Violence in Families: Assessing Prevention and Treatment Programs*. Washington, D.C.: National Academy Press.

Crowe, H., & Zeskind, P., (1992). Psychophysiological and Perceptual Response to Infant Cries Varying in Pitch. *Child Abuse and Neglect*. 16.

Garbarino, J. and Kostelny, K. (1992). Child maltreatment as a community problem. *Child Abuse and Neglect*, 16, 445-464.

Gray,J., Cutler,C., Dean,J., & Kempe, C.H. (1979). Prediction and prevention of child abuse and neglect. *Journal of Social Issues*, 35(2), 127-139.

Guterman, N.B. (1997). Early prevention of physical child abuse and neglect: Existing evidence and future directions. *Child Maltreatment*, 2, 12-34.

Hiarr, S. W., Sampson, D. and Baird, D. (1997). Paraprofessional home visitation: Conceptual and pragmatic considerations." *Journal of Community Psychology*, 25(1), 77-93.

Jongema, A. E., Peterson, M., (1995). *The Complete Psychotherapy Treatment Planner*. New York: John Wiley.

Kitzman, H., Olds, D.L., Henderson, C.R., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K.M., Sidora, K., Luckey, D., Shaver, D., Engelhardt, K., James, D., & Barnard, K. (1997). Effect of prenatal and infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *JAMA*, 278, 644-652.

Kumpfer, K., Celvarado, R., (1997). Effective family strengthening interventions. *OJJDP Juvenile Justice Bulletin*, 1-13

Lifur-Bennet, L. (1982). The effects of an Adlerian and a behavioral parent-education program on learning disabled children and their parents. Unpublished Ph.D. dissertation, California School of Professional Psychology, Los Angeles.

Lutzker, J.R., Wesch, D., & Rice, J.M. (1984). A review of Project 12 Ways: An ecobehavioral approach to the treatment and prevention of child abuse and neglect. *Advances in Behavioral Research and Therapy*, 6, 63-73.

Markman, H.J., Resnick, M.J., Floyd, F.J., Stanley, S.M., & Clements, M. (1993). Preventing marital distress through communication and conflict management training: A 4- and 5-year follow-up. *Journal of Consulting and Clinical Psychology*, 61, 70-77.

McBride, B.A., (1991). Parental support programs and paternal stress: An exploratory study. *Early Childhood Research Quarterly*, 6, 137-149.

Milner, J., Halsey, L., & Fultz, J. (1995). Empathic responsiveness and affective reactivity to infant stimuli in high and low-risk for physical child abuse mothers. *Child Abuse and Neglect*. 19:6.

Olds, D. & Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. *The Future of Children*, 3, 53-92.

Olds, D., (1997). Long-term effects of home visitation on maternal life course and child abuse and neglect. *JAMA*, 278 (8), 637-643.

Olds, D., Henderson, C., Chamberlin, R., Tatelbaum, R., (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 78 (1).

Olds, D., Hill, P., & Rumsey, E. (1998, November). Prenatal and early childhood nurse home visitation. *OJJDP Juvenile Justice Bulletin*, 1-7.

Polansky, N.A., Gaudin, J.M., Ammons, P.W., & Davis, K.B. (1985). The psychological ecology of the neglectful mother. *Child Abuse & Neglect*, 9, 265-275.

Showers, J. (1992). Don't shake the baby: The effectiveness of a prevention program. *Child Abuse and Neglect*. Vol. 16.

Thompson, R.W., Grow, C.R., Ruma, P.R., Daly, D.L., & Burke, R.V. (1993). Parent education: Evaluation of a practical parenting program with middle- and low-income families. *Family Relations*, 42, 21-25.

Tyson, P., & Sobschak, K. (1994). Perceptual responses to infant crying after EEG biofeedback assisted stress management training: Implications for physical child abuse. *Child Abuse and Neglect*. 18:11.

Wesch, D., & Lutzker, J. (1991). A comprehensive 5-year evaluation of Project 12 Ways: An ecobehavioral program for treating and preventing child abuse and neglect. *Journal of Family Violence*, 6, 17-35.

Community

When we think of community, it is important to think beyond the idea of location... where people live. Community can be either geographical or functional, or a combination of the two. While “geographical” does refer to one’s location, neighborhood or residence, “functional” refers to circumstances where there exists common interest, association, occupation or services.

A community can be defined “as a network, or informal relationships between people connected to each other by kinship, common interest, geographic proximity, friendship, occupation, or giving or receiving of services – or various combinations of these” (cited in Martinez- Bradley, 1995, p.546). The Outreach Manager’s Guide (1998) describes the Air Force community as both functional and geographical:

- functional in its organization around units where relationships exist because of the common issues related to the mission of the unit and of the connection of active duty families
- geographic when we speak of the installation, base housing neighborhoods, and local civilian neighborhoods that include some AF family residents (p.IV-3).

Other important concepts that will help you define activities associated with your role in the NPSP include:

- **community capacity** referring to the ability of a community to bring its members together to meet their needs and goals, jointly solve problems, reinforce prosocial norms, provide opportunities for meaningful participation, provide and express support, respond to external threats, maintain stability and order and create a psychological sense of connection or belonging.
- **cohesion** defined when a productive social unit with common efforts and goals is established .
- **community capital** existing in the social, emotional, spiritual, or physical resource or investment that an individual, family, neighborhood or group has in the community.
- **macro-system intervention** demonstrated when service activities are focused on broad-based issues that impact the public or community-at-large.

More extensive definitions can be found in the Community Resilience chapter of the Outreach Manager’s Guide. Your understanding of these concepts support FAP efforts in operationalizing community-level intervention.

FAP Prevention Program Elements

The challenge for FAP staff is to embrace the paradigm shift to *New Directions in Prevention*. **Collaboration, Advocacy, Education and Skill Development, Community Intervention, Training, Marketing, Referral and Resource Linking** are all prevention program elements. The FAP Outreach Manager serves as key coordinator and facilitator for FAP prevention and these listed prevention program elements, but it takes all of us working together to make community care a reality.

Comprehensive service delivery requires teamwork. Whether you are a Family Advocacy Program Nurse, Family Advocacy Program Assistant, Family Advocacy Officer, an Outreach Manager or Treatment Manager, prevention is a part of your responsibility. While that means change in the way we do business and in the way we see our roles, it is change that will reap great benefits for active duty and their families and for our communities. That is where our focus must be...on customer care and program participant satisfaction. “Stove piping” our efforts hinders our ability to support families in the best way possible. Our families and community deserve the best.

Collaboration and Teamwork can only enhance the performance and the outcome of our programs and services. Working together internally and with other agencies through the Integrated Delivery System (IDS) expands the pool of ideas and interests and allows stakeholders to invest themselves and their resources toward the success of prevention initiatives.

Advocacy work ensures that issues of policy and the special interest and needs of the AF base community are brought to the attention of base and community leadership. The FAC and the CAIB are two important resources for family and community advocacy.

Education and Skill Development enhances the knowledge, skills and abilities of families and provides tools for relationship building, problem solving, life management, and early identification of personal and community services needs.

When the impact of social or health issues is broad-based, it is through **Community Intervention** that we establish partnerships with community leaders, formal agencies and informal groups in local towns and neighborhoods to address community needs.

Training provided to base and community agencies on the dynamics of family violence, the recognition of child or spouse maltreatment, and the procedure for a referral for help is value added to the mission of the FAP. Ensuring that the community is aware and knowledgeable of AF FAP prevention and treatment programs is a unique responsibility of the Family Advocacy Program.

When we can provide **Referral** services and link AF families to base and community resources and support them in developing their own networks and support systems within their communities, we are contributing to the enhancement of their ability to develop prevention strategies, activate community capacity, and utilize their empowerment to establish connections.

A critical point in the *New Directions in Prevention*, is an emphasis on **Marketing**. Marketing allows us to inform the community of our product lines...prevention and treatment of family maltreatment, and building healthy families and communities. In order to engage the community in partnership with FAP as advocates for nonviolent homes and communities, it is imperative to determine what they want and what their strengths and needs are.

Business marketing generally has as its goal to sell a tangible product. Our work requires social marketing. We teach, persuade, and encourage ideas, life principles and change. We seek to affect awareness, attitudes, and behavior; to maximize knowledge, skill and ability; and to influence leadership support, active duty readiness, family cohesion and life management, and community capacity and resilience.

Conducting a market analysis and developing a marketing plan are important steps in preparing to develop effective public relations. These efforts are key in promoting leadership, family and community interest in collaborating with us and in investing in the programs and services we offer. However there is something that can have far greater impact than any formal marketing campaign we implement, and it is this step to which we must give special attention. As Family Advocacy Program staff, we send messages about the FAP services and activities with each encounter we have. *And so, FAP marketing really begins with us.*

It is crucial for FAP staff to understand

- the social and political environment in which we work,
- the nuances, traditions and protocols of the AF culture,
- mission and perspectives on readiness by AF leaders and active duty
- the perceptions of military families and the local community about family maltreatment and the FAP as a helping resource.

FAP marketing will be impacted by all of these.

Equally important is the Family Advocacy Program staff's understanding of the FAP. Careful consideration should be given to key questions like:

- "What is the rationale for the Family Advocacy program?"
- "What purpose does it serve?"
- "What do I believe individually about the importance of the Family Advocacy Program?"

Also important is consideration of one's personal and professional commitment to the principles that the FAP promotes. For some, this may bring up issues that make us feel uncomfortable, and therefore may require a bit of self-assessment, some value clarification, a kind of internal marketing. Just as we must assess program participants, we, too, are assessed by our customers and program participants. We cannot give a convincing message about the benefits of the Family Advocacy Program unless we ourselves are convinced. Marketing is a part of the paradigm shift that places emphasis on providing a clear, positive and effective message to the community about the prevention of family maltreatment and building healthy communities.

Teamwork

Teamwork is a critical process in FAP prevention. Working in collaborations and partnerships, both internally and externally, is a central theme for all our prevention efforts. FAP staff must work as a multi-disciplinary team with the client/program

participant in mind. Using the diversity of skills on the team fosters best practices in the provision of services.

An important principle in *New Directions in Prevention* is to insure that a partnership exist with the client/program participant. Often, the service rendered is assistance to informal community leaders in developing neighborhood teams and forging group connections. For example, the NPS team may be requested to provide guidance or other support to a local group of new parents in advocating for quality child care or in developing childcare co-ops.

An excellent vehicle for program support and collaboration with external agencies is the Integrated Delivery System (IDS). This team is established to design, plan and implement shared agency prevention responsibilities and initiatives. The FAP representative to the IDS is the Family Advocacy Outreach Manager, who is responsible for insuring that NPSP issues are heard and marketed to the IDS, and that the IDS team addresses NPSP prevention.

Participation in the New Parent Support team case staffing meetings is another opportunity for teamwork. Meaningful contribution by each member enhances the strength and viability of the team. Remember that families and program participants are the focal point of our services and a team approach provides the best opportunity for efficient support in building healthy communities.

The continued growth and evolution of the FAP requires flexibility and resilience from each member of the FAP team. We are each challenged to rethink our traditional approaches to our mission and to expand the boundaries of our individual roles in working with families and the AF community. *New Directions in Prevention* challenges the total FAP staff to utilize the diversity of their skills, education and experience as a cross functional team. This partnership of direct services and community intervention facilitate healthy families and community resilience. In the Family Advocacy Program, prevention must be integral to everything we do.

Linking Community Resilience and the NPSP

As a member of the New Parent Support team, you contribute to building healthy communities through secondary prevention and community level intervention. Addressing prevention issues that impact the community at large, families with intensive needs, and those who simply wish to enhance their knowledge, skill and ability are equally important to the development of resilient communities.

Community Resilience is demonstrated when a community is able to “bounce back”, recover, or sustain itself over time after having experienced adversity. The degree to which a community is able to bounce back is in part due to its community capacity. In the Family Advocacy Program, a goal is to create an environment that fosters family

adaptation and community capacity. We know that when a community has the ability to bring its members together and facilitate a sense of belonging, this has occurred through their collective engagement in a variety of actions. Among them include:

- accepting opportunities for meeting individual and collective needs and goals
- engaging in meaningful participation in the community and
- providing and receiving instrumental and expressive support.

These represent some of the factors that influence community capacity.

Family adaptation, consistent with Bowen, Orthner, and Bell (1997), is defined as an “outcome of the family’s efforts to cope and adjust in meeting the individual and collective needs of its members and in responding to external demands” (Bowen, Orthner and Bell, 1997. p-54).

The NPSP has a primary objective to empower families. Assisting new parents in acquiring knowledge, learning new options for problem solving and decision making, aimed at preventing family maltreatment are all important program activities. The challenge is to assist program participants to reach out to others in the community and develop connections; to take charge of their own wellbeing; and advocate for themselves. The Link of Community Resilience to the NPSP is in allowing program participants to collaborate and form partnerships with us and with others associated with formal agencies, for support in their endeavors to maintain independence.

Remember, there is interdependency among the family, the work unit, and community levels of social capacity. Deficits in social capacity at one level may help compensate for deficits at other levels (Bowen, 1998). Your activities for the NPSP must address these interconnected entities, incorporating both attention to the secondary clinical intervention needs of families, and the broadbased issues that impact the whole community.

References

Bowen, G. L., Orthner, D. K., and Bell, D. B. (1997). Difference in Spouses Perceptions of Family Adoption. *Journal of Social Behavior and Personality* 12, 53-72.

Bowen, G. (1998) *Community Resiliency: A Research Roadmap*. (Unpublished Report.) Chapel Hill. The University of North Carolina at Chapel Hill, School of Social Work.

USAF Family Advocacy Program. (1998). *Outreach Manager's Guide*.

AF Family Advocacy Program Home Visit Prevention Program

In an effort to expand the prevention component in 1986, a working group of Air Force social workers was convened to revise the FAP. Two major outcomes resulted: a) Expand the scope of prevention activities, and b) program evaluation component to measure intervention effectiveness. These two changes augmented and expanded the continuum of Air Force Family Advocacy services and established evaluation as a major component among Air Force FAP programs. Today, program evaluation is a hallmark of Air Force FAP.

In response to the decisions of the working group, the FAP Director of Research designed a maternal child home-visitation program to prevent child abuse, linking the best practice on child abuse prevention programs and home visits. Findings from the David Olds study (Olds, Henderson, Chamberlin & Tatelbaum, 1986) and the “Hawaii Healthy Start” (Department of Health, State of Hawaii, 1992) home visit programs influenced the design and development of services targeted toward new parents in the Air Force, called the First Time Parents (FTP) Program. This revolutionary program recognized that parenting is extremely demanding for all families. It sought to enhance protective factors within an Air Force environment where social support systems can be limited and the lack of community linkages can be challenging and stressful for young military families.

A report published by the U.S. Government Accounting Office (GAO) in 1990 validated the home-based prevention focus the Air Force was taking. The GAO concluded that home visitation is an effective service delivery strategy for improving the health and well-being of families and children, and provided a framework for improving such programs. Their analysis determined that home-visited families had fewer low birthweight babies, higher immunization rates, more age-appropriate child development, and fewer reported cases of child abuse and neglect. The following year, the U.S. Advisory Board on Child Abuse and Neglect (1991) published a report that recommended the federal government phase in a national universal home visiting program for children during the neonatal period. Their recommendations were based on the social and economic impact of child abuse and the rapidly increasing focus and awareness of this phenomenon.

The Air Force pilot-tested the First Time Parents Program at eight Air Force bases. This voluntary home-based program was staffed with professional community health nurses, called Family Advocacy Nurses (FANs). They targeted first-time parents who had not experienced a child abuse incident but were at risk for abuse. FANs were strategically placed between the Family Advocacy Outreach Program, maltreatment program components, and military medical services. The goals of the program were to prevent child abuse and neglect among Air Force families, improve family life skills, and enhance military readiness by providing psychosocial and maternal child educational and support services to young parents during this stage of family life.

The Literature and Home Visit Programs

The literature on early intervention home-visitation programs for at-risk families documents positive outcomes. Studies conducted with registered nurses providing interventions in the area of improving maternal child health in pregnant women reduced the incident of child abuse and neglect (Olds et al, 1986). Both social support and health information provide a full continuum of services that are required during this life cycle development of parents expecting their first child so that families' attainment of positive health and social outcomes in family management can be accomplished. In addition, the literature on prenatal families and families with children supports an ecological model. This model is a blend of both social support and public health models addressing the importance of health-related behaviors and social support during pregnancy and subsequent care of the child in his/her early years (Olds and Kitzman, 1990). The philosophical view of delivering services in the home ties to the empowerment, enablement, and enhancement of the parents (Wasik, 1990). Parents are empowered by their ability to closely guide the development of their personal objectives and goals they wish to fulfill through program participation.

Home visit programs provide families with information about child health, infant care, information and support in managing military family life events in general with the goal of preventing child abuse. Home-based interventions are diverse and tailored for each family as they adapt to parenthood, focusing on the prevention of child abuse. While in the home, many teachable moments and opportunities are available for providers to support, give anticipatory guidance, educate and link families to available community services .

REFERENCES

- Bandura, A. (1977). Self-efficacy: Toward a unifying theory of behavioral change. *Psychological Review*, 84, 191-215.
- Brewster, A.L., Nelson, J.P., Hymel, K.P., Colby, D.R., Lucas, D.R., McCanne, T.R., & Milner, J.S. (1998). Victim, perpetrator, family, and incident characteristics of 32 infant maltreatment deaths in the United States Air Force. *Child Abuse & Neglect*, 22, 91-101.
- Department of Health, State of Hawaii. Report to the Sixteenth Legislature State of Hawaii (1992) On House Bill No. 139, C.D.1 Requesting Review and Recommendations from the Director of Health on the Healthy Start Program. Report prepared by Personal Health Services Administration, Family Health Services Division, Maternal and Child Health Branch.
- Donnelly, A.C. (1992). Healthy Families America. *Children Today*, 21, 25-28.
- Mercer, R.T. (1998) *Transitions to parenthood*. Sunnyvale, CA: NurseWeek Publishing.
- Milner, J.S. (1986). *The Child Abuse Potential Inventory: Manual (2nd ed.)*. Webster, NC: Psytec.
- Mitchell, S, Magyary, D, Barnard,K, Sumner,G, & Booth,C.(1988). *Families in transition: Primary programs that work*. Beverly Hills, CA: Sage, 1988, 73-98.
- Mollerstrom, W.W., Patchner, M.A., & Milner, J.S. (1995). Child maltreatment: The United States Air Force's response. *Child Abuse & Neglect*, 9, 325-334.
- Olds, D.L., Henderson, C.R., Chamberlin R., & Tatelbaum R. (1986). Preventing child abuse and neglect: A randomized trial of nurse home visitation. *Pediatrics*, 78, 65-78.
- Olds, D.L., & Kitzman, H. (1990). Can home visitation improve the health of women and children at environmental? *Pediatrics*, 86, 108-116.
- Olds, D.L., & Kitzman, H. (1993). Review of research on home visiting for pregnant women and parents of young children. In R.E Behrman (Ed.), *The Future of Children--Home Visiting* (pp. 53-92). Los Altos, California: The David and Lucile Packard Foundation.
- Olds, D.L., Kitzman, H., Cole, R., & Robinson, J. (1997). Theoretical foundations of a program of home visitation for pregnant women and parents of young children. *Journal of Community Psychology*, 25, 9-25.

Sumner, G. (1990). *Keys to Caregiving: Self instructional series*. NCAST Publications. Seattle, WA: NCAST Publications.

U.S. Advisory Board on Child Abuse and Neglect. (1991). *Creating caring communities: Blueprint for an effective federal policy on child abuse and neglect*. Washington, DC: U.S. Government Printing Office.

U.S. Department of Health and Human Services, Childrens Bureau. (1996). *Child maltreatment 1996: Reports from the States to the National Child Abuse and Neglect Data System*. Washington, DC: U.S. Government Printing Office, 1998.

U.S. Government Accounting Office. (1990). *Home Visiting. A promising early intervention strategy for at-risk families*. (GAO/HRD Publication No. 90-83). Washington, DC: Author.

Wasik, B.H. (1990). *Home Visiting: Procedures for helping families*. Newbury Park, CA: Sage Publications.

CHAPTER IV

New Parent Support Program Operations

A. New Parent Support Program – A Voluntary Universal Program

The AF offers NPSP services to all families of active duty members who have children aged birth to three years, or a pregnant spouse. We are committed to developing a voluntary universal program to ensure positive perception and access for all new parents. FAP team members work in partnership in the provision of these program services that vary in intensity and modality from community-based classes and groups to home visits, according to assessed family need. However, all NPSP participants, whether they have been determined as low or high needs, may participate in NPSP community activities and programs. NPSP participants will be screened using the *AF Family Needs Screener(FNS)* for the purpose of determining if they are likely to have low or high service needs. Domains on the FNS are linked to risk factors for family maltreatment and include:

- Stress
- Relationship discord
- Support issues
- Substance Abuse
- Violence approval
- Family of origin violence and neglect
- Depression
- Prior family violence

Participants screened as “high needs” will be offered a home visit which includes use of standardized instruments and interviews to assess risk of family maltreatment. Families assessed as “high needs” will be offered more intensive NPSP services including ongoing home visits and participation in community services, classes and groups available to NPSP families. NPSP program activities must also be focused and linked to the NPSP program goals in order to effect program and clinical practice outcomes. The NPSP Logic Model program goals are:

- Decrease Potential to Maltreatment
- Increase Knowledge of Child Growth and Development
- Enhance Family Member Role Adaptation
- Increase Problem Solving Skills

NPSP Community Services

Community prevention educational and support programs focused on the reduction of family violence can be delivered via classes, groups, and agency programs as well as home visit programs. NPSP community-based services are activities that are delivered via informational “mail outs”, special parenting courses, agency referrals, and

participant-driven support groups. These activities are available to all NPSP parents in the AF community. The challenge for the team is to engage NPSP families in these community-based education and support programs centered on early child growth and development, positive child disciplinary techniques, stress management and family life skills. The NPSP identifies and assures the availability a range of educational and family life skills and community activities for all NPSP families.

Components of community parent educational and support programs are areas for the team to focus their activities which impact NPSP program goals. For example, parental competence component activity would include teaching fathers how to calm a crying baby by teaching him newborn language. Components and examples of community educational NPSP activities are:

- *Social Isolation Support*
A key component linking families to formal and informal support systems.
- *Parental Competence*
Addressing parents lack of knowledge in child growth and development.
- *Stress Management*
Building skills to reduce stress.
- *Marital Violence*
Prevention of partner violence through marital enrichment programs couples communication and problem solving skills.
- *Family Health Promotion*
Providing health education knowledge to empower participant to access health care systems and apply self-care health promotion practices.

Comprehensive NPSP Assessment

NPSP participants assessed as *high needs* using the FNS and a NPSP clinician team member assessment will be offered intensive interventions via home visits by the NPSP team, referrals for additional clinical and agency services and participation in other NPSP community activities. The NPSP clinician, a nurse or social worker, will perform a comprehensive assessment in addition to the *FNS*. Additional clinical assessment instruments and interviews are conducted for the purpose of formulating an assessment of the risk of family maltreatment, needs for services and development of a Family Service Plan.

Additional instruments used to gather more information with all families receiving home visits are the Parenting Stress Index, the Home Observation and Measurement of the Environment (HOME), and the Ages and Stages Questionnaire (ASQ). The intent is to identify family strengths and areas that require intervention. Assessment will include both the participant's health promotion knowledge and psychosocial risk assessment to help identify intervention participants and family goals and objectives.

Home Visiting

A report published by the U.S. Government Accounting Office (GAO) in 1990 concluded that home visitation is an effective service delivery strategy for the prevention of child abuse. They recommended the use of home visitation as an effective method to improve the health and well being of families and children. Their analysis determined that home-visited families had fewer low birthweight babies, higher immunization rates, more age appropriate child development, and fewer reported cases of child abuse and neglect.

The literature on early intervention home-visitation programs for at-risk families documents positive outcomes (Olds et al, 1986) in the area of reduced incidence of child abuse and neglect. Both social support and health information provides a full continuum of services that are required during this life cycle development of parents. The literature on prenatal families and families with children supports an ecological model. This model is a blend of both social support and public health models addressing the importance of health-related behaviors and social support during pregnancy and subsequent care of the child in his/her early years (Olds and Kitzman, 1990). The philosophical view of delivering services in the home ties to the empowerment, enablement, and enhancement of the parents (Wasik, 1990). Parents are empowered by their opportunity and ability to closely guide the development of their personal objectives and goals to fulfill through program participation.

Unique military factors, such as frequent job-required separations, great distances from extended families, and frequent moves that disrupt the establishment of social support networks, can lead to stress among young military family members. Interventions focused on family violence prevention, child health, infant care, and information and support in managing military family life events offer an important resource to new parents who are experiencing challenging life events that are magnified by these unique factors.

While in the home, many “teachable moments” and opportunities occur to provide support, anticipatory guidance, education and linkage of families to available community services. NPSP home visits are designed to be intensive with a nurse or social worker providing services and may include the assistance of the Family Advocacy Program Assistant. *Home visits will be conducted at least once a month and can last for up to 2 hours depending on family needs.*

Tailored Family Service Plans

All NPSP participants, low needs and high needs, will have a service plan developed by the FAP NPSP team that includes community services or activities and some may include home-based interventions. NPSP services are diverse and tailored for each family as they adapt to parenthood, but are focusing on the prevention of child abuse and the NPSP program goals.

B. Marketing NPSP

Comprehensive marketing efforts with prospective customers or participants, key line and community leaders, and installation helping agencies that serve pregnant women and families with children from birth to three years of age will ensure a stream of referrals to NPSP. Some referrals may come through informational briefings to OB orientation or other groups attended by families with young children. Other referrals may come from first sergeants, medical providers, or personnel from other helping agencies, such as the Child Development Center or the Family Support Center. Self-referrals are also an important source of new participants.

Marketing is a key process for the New Parent Support Program. It provides opportunities for enhancing awareness, educating, motivating and impacting change in knowledge, attitudes and behaviors. It is our vehicle for reaching the community and recruiting program participants through media processes and briefings.

If someone asked you what you were doing to market your New Parent Support Program, do you immediately think of brochures, flyers, slogans, etc.? When most people talk about marketing, they usually mean advertising or publicity. But those are actually just activities that should result from the process of marketing. Many programs suffer from poor attendance because service providers neglect one of the most important elements—marketing. Effective marketing involves far more than just publicity.

Advertising may not be synonymous with marketing, but a good marketing strategy will definitely include advertising. Marketing techniques or activities include four key areas:

- **Advertising:** a public announcement that identifies the product, increases the customer's awareness and emphasizes the value or advantage of the product.
- **Promotion:** activities that use a specific strategy to bring special focus and generate interest.
- **Publicity:** actions that highlight the product or service in order to reinforces your audience's attention and act as a reminder.
- **Public relations:** the process of networking, persuading, or developing the support of your target audience.

So, now that you want to market your NPSP, where do you begin?

The first step begins with a needs and assets assessment and a market analysis, followed by the development of a marketing plan. This NPSP marketing plan must be directly related to and supportive of the Prevention Plan, a compilation of programs and services, each identified in Prevention Service Action Plans (See AF FAP Standards P-4 and P-5).

Not only does a marketing plan help in creating and sustaining quality programs, but a plan can also guide creative thinking and planning on reaching your target audiences most effectively. Here are some key steps to a successful marketing strategy for NPSP:

- Write a marketing mission/position statement.
- Identify marketing goals.
- Understand and reach your target audiences.
- Develop a key message or slogan.
- Choose the most effective delivery mechanisms for your target audiences and community.
- Be consistent in following up and supporting your strategies.
- Conduct a marketing evaluation.

These processes are some of the foundations of marketing. Keep them in mind and refer to Appendix G for additional social marketing information and tools. The rest of this section will focus on some practical considerations in developing and implementing social marketing strategies.

First of all understand that you will be marketing to different populations and groups. The approach you take and the type of information you provide will depend upon your selected audience and the purpose of your marketing efforts. You will receive referrals for the NPSP from a variety of sources and these should also be the foci of your marketing efforts. Some examples of marketing audiences include the following:

- New Parents (intensive needs? low needs?)
- Active Duty new parent
- New fathers
- First Sergeants
- Commanders
- AF Medical Treatment Facility (MTF) Providers
- Installation and local community agency providers
- Base and local community population

Marketing is not a one-size-fits-all effort. Each type of customer requires an individualized marketing strategy because different products and approaches will move

each group. Only when you understand your audience can you put together a public relations or promotional campaign for your program.

In order to reach your selected audiences effectively, you have to demonstrate how what you do benefits them. In addition, you must convince them to spend their time, energy and/or childcare dollars in order to participate in your programs. For example, commanders and first sergeants will be one of your major customer groups. Many people find that when working with this group, an approach that emphasizes readiness and demonstrates how NPSP can support that readiness will gain the most support.

MTF personnel, another major customer group, will respond better by knowing how NPSP can support their patients' health needs, enhance wellness and thus ultimately reducing the demand for acute care services. When addressing your primary customer group—families you want to use NPSP services—you may want to emphasize a warm, caring program that can provide specific services that these families want.

When developing your strategies for briefings or public speaking situations, keep in mind such items as time, location, format of marketing presentation, and the focus and building of your message.

Time – Keep in mind the meaning of time to the commander, the at-home parent, the active duty member, MTF staff, the base community (at commanders' calls, etc.). Time is important to each but there may exist special constraints that must be considered. For example a wing commander's schedule would likely require a brief, clear, succinct message.

Location – The commander's office may be one of the choice locations for such a briefing (meeting) but numerous commitments may require that you follow the commander's executive staff guidance lead as to a convenient and timely meeting.

Format of Marketing Presentation – Be prepared with the message you want to present. Don't speak off-the-cuff unless you have especially good skills at recalling the basic facts that leave the audience understanding a straight-forward message and interested to know more. At the same time, reading a prepared briefing may bore your audience. One option is to speak from an outline of your key points. Practice helps!

Marketing also means increasing visibility as part of your everyday NPSP business, e.g., using your logo consistently on anything printed for the program or providing promotional literature, signs, tent cards, folders, or banners whenever you interact with customers. Equally important, *make sure your NPSP team lives the image it wants to project—that it “walks the talk.”* Remember that it's always easier to create a positive image than to change a negative or neutral one. Your commitment to the principles, goals, and objectives of FAP and the NPSP will be instrumental in this process.

Actually, marketing occurs any time that a customer interacts with any NPSP team member, publication or process. For example, people will judge your NPSP by how team members answer the telephone or interact on committees, the quality of your brochures or handouts, the appearance of team members and facilities, by the degree of enthusiasm the NPSP has for the program or by the perceived quality of services received.

Marketing is an activity that is never over or perfectly executed. Thus, a key component of any marketing plan is a strategy for measuring how you're doing during and after the execution of the plan. This plan should evolve and change if you evaluate how you are doing throughout the process. Thus, as you learn more about a particular audience, you might want to modify your goals for that group. You might even consider a second round of strategies if your original approach did not lead you to the final goal. Remember—marketing never ends. It is a process that must be an integral part of your everyday operation.

C. Developing Community Services for the NPSP

The Role of Community Services in the NPSP

The ready availability of community education, support and community resilience-building services and activities for families with pregnant spouses or children aged birth to three years is crucial to the success of the New Parent Support Program. The NPSP is grounded in community-based services that meet the needs of all its participants. Community-based services are the primary services received by the majority of NPSP participants.

The goals, objectives and activities of community services for NPSP participants are spelled out in the NPSP logic model (See Chapter III) and in the roles of some of the members of the NPSP team (See Chapter V). In developing the menu of community services for your NPSP, there are several important considerations:

- Community services need not be provided by the NPSP or FAP staff. In fact, it is extremely unlikely that a given FAP could resource a full range of NPSP community services.
- Community services need not be labeled as NPSP services or exclusive to NPSP participants, but they must be readily accessible to and appropriate for NPSP participants.
- Community services need not be designed exclusively for families with young children or pregnant spouses, but they must be effective in meeting the needs of these families.
- Community services **MUST** be geared toward reaching NPSP goals for program participants (See Chapter III on logic models).
- Community services **MUST** be attractive and easily accessible to NPSP participants.
- Community services **MUST** be focused toward building the resilience of the community of families with young children or pregnant spouses.

So, what does all this mean?

Your NPSP needs a range of community services that

- are easy for NPSP participants to access,
- are tailored to their needs, meet program goals for participants, and

- enhance the resilience of the community of these young families, the connections among and the networks of informal support systems and formal helping agencies and command that support them.

Programs that are easy to access are receptive to these young families, are located and scheduled to their convenience, have minimal or no waiting lists, can accommodate the presence or schedules of their young children, and have minimal if any cost. Program tailored to their needs are aware of and sensitive to the issues and concerns of young families, and provide services and opportunities that are judged by participants to be worth the time and financial costs.

Programs and services that build the resilience of the community of young families are those that help families build their own networks of relationships with other young families with common interests. These programs also enhance families' awareness of available supports and services within the community, both informal associations and formal agencies. Ultimately, these programs and services facilitate the community of young families' ability to organize to provide their own services and meet their own needs. An example might be a neighborhood group that organizes its own babysitting co-op with the initial assistance of Family Support Center staff.

Community services are designed to address the broad-based needs of the community and to support and facilitate enhancement of individual, family and community strengths. The focus on building strengths in community services is a resilience-enhancing perspective that enables helpers to develop programs that go beyond the traditional efforts to ameliorate individual and family deficits.

The Outreach Manager (FAOM) is the primary facilitator for the community component of services for FAP prevention. The FAOM identifies, coordinates and links broad-based community services. Where there are service gaps, the FAOM, in collaboration with the FAP prevention team and the IDS coordinates and facilitates the planning, implementation and often the design of community and outreach activities. Community services include education and skill development, advocacy, training, community intervention, referral and resource linking and marketing, and are the key FAP prevention program elements of the Family Advocacy Outreach Manager Role. When devising NPSP marketing and community services, the FAOM leads the team in developing an understanding of the unique requirements of young families, and of the community in responding to their needs.

Community services may include

- family life education support,
- learning and action advocacy groups,
- family maltreatment identification and prevention briefings,
- marketing strategies for community awareness and participation,
- training of professional and paraprofessional human services personnel,
- accessing services for program participants and the community, and

- a variety of appropriate other *connection-building* prevention initiatives.

As a universal program, the NPSP encompasses home visitation as well as community education and advocacy services, depending on the intensity of services needed. The unique aspects of the Air Force NPSP for its participants and staff are its community-based services.

Steps in Developing Community Services for the NPSP

With the Outreach Manager as facilitator, the entire team is involved in determining the scope and extent of NPSP community services. The NPSP team should determine responsibilities in the development of needed community services, using the talents and expertise of each to obtain the best possible palette of community services. The NPSP team works in collaboration with the installation Integrated Delivery System to locate or develop community services for the NPSP. It is also important to involve NPSP participants in this process. An active process is required and involves the following steps. Although they are presented sequentially, some steps may overlap or occur simultaneously.

1. Survey Installation and Civilian Community Agencies, and Key Customers to Determine Availability of Services for NPSP Families.

Your team will be familiar with some of the services available, especially those associated with the scope of our traditional focus on first-time parents. Even for known services, it is important to ascertain

- the nature of the services,
- types of participants best suited to the program or for whom the program is likely to be most effective,
- the current status of the program,
- any entry fees or other requirements (including waiting lists), and
- preferred mechanisms for making referrals.

The survey can consist of informal phone calls to members of key agencies. It is important for the team to agree on a list of questions to ask each agency so that the information is consistent across services. It may be helpful to develop a simple one-page form with key areas to cover that can be completed by the NPSP staff member during or after a phone call or visit to a program.

It is also important to talk to some of your NPSP's key customers to get their input on service needs. First sergeants can usually pinpoint important problem areas and difficulties in addressing them. They can also tell you their perceptions of the accessibility of community and installation agencies in addressing the problems they have identified. Families currently served by the NPSP can give you their ideas on services they would like to have available. Of course, if you find that such services are

readily available, you have identified another type of problem, namely, knowledge of community services and their availability. A focus group of families with young children or pregnant spouses might be set up. It would be important to include a broad range of families, whether or not they have participated in the NPSP. Installation agencies that regularly see these families, such as the Child Development Center or OB Service, might be helpful in locating several parents to participate.

2. Further develop your team's knowledge of the needs and interests of families with children aged birth to three years or pregnant spouses.

When your team gets together to begin to identify community services, you're likely to find that together you have a lot of expertise on these families. Team members may have books, articles, or other resources to share. (Also, see Chapter VI.) Other sources of information to tap include:

- Installation and community experts. Some might be surveyed during the phone calls to check out available community services. A question or two might be added to the survey asking the informant's experiences with services for young families – most popular, most useful, any barriers to family participation, etc.
- “Surfing” the web for information and service models.

3. Determine gaps in community services for families with young children.

If it hasn't happened yet, this is the point at which you will want to get your installation Integrated Delivery System team involved. Present the findings of your formal or informal survey of available programs and services. Obtain feedback on services that have been used as referral sources by other IDS members, and input on other agencies that might be contacted. It is important to include first sergeants, or other command representatives, in these deliberations.

4. Establish a list of the key community service needs of families with young children in your community. Set priorities among the service needs.

If it hasn't happened yet, this is the point at which it is crucial to involve community members, namely, families with children birth to three years or pregnant spouses, in the planning process. The essence of community advocacy and resilience-building is *shifting from “doing for” the target or focus population to “doing with”* and supporting the work of informal community leaders. This shift can be difficult when we are used to thinking in terms of clients (and their problems), who can be helped by the services we develop and provide.

Involving community members and informal leaders creates the possibility of active collaboration with the group or members of the group we want to serve. Of course, we include our command and installation and community agency partners in this process.

Potential outcomes include:

- community services that are better attuned to the needs of young families,
- community services that are more effective in achieving their goals,
- increased resources (families and community agencies) to provide the services,
- personal and family growth for community and agency participants,
- enhanced informal networks among community participants in the service planning and delivery process, and ultimately
- enhanced resilience of the community of families with young children.

5. Starting with the top of your prioritized list, work to develop and implement the needed services.

By this time, the community, command and agency representatives mentioned in item number four above have become a formal or informal steering group for the NPSP, actively engaged in the tasks of understanding and responding to the needs of families with or expecting young children. The group uses its collective creativity and skills to actively involve the community of young families in meeting their needs and enhancing individual, family and community resilience. The group might devise its own programs or services, or use models and materials from other communities. They may need advice and assistance in developing ways to evaluate their efforts, programs and services. The *Outreach Manager's Guide* is a good starting point for understanding community resilience, and guidelines on program development and evaluation.

6. Establish mechanisms for ongoing evaluation and revision of current services, assessment of additional needs, and development and implementation of new services.

Again, your network of community participants, command and agency representatives are crucial to these tasks. Periodic, systematic reviews of current services will help the group improve the effectiveness of community services in serving the community and achieving NPSP goals. In this time of perpetual change, it is also important to be able to determine shifts in needs of members of the community of young families. The development of new services generally depends on identifying unmet needs of some real concern, finding community members willing to champion program development, and community members and resources that can be tapped to provide new services. The collaboration of a broad range of community members, informal leaders, command and agency representatives creates the greatest possibility that these factors will be present and that NPSP community services will grow dynamically to meet the needs of its participants.

Minimum Requirements for NPSP Services

While community services for NPSP must be based on the assessment of local community needs and resources, there is a discreet minimum level of community services sufficient to support NPSP families in meeting their goals and the goals of the program.

So, how many and which community services are required for the NPSP?

To answer this question, look at the NPSP goals. These include:

- Enhancing the health and wellbeing of families with young children or pregnant spouses, and preventing child and spouse abuse.
- Increasing family member role adaptation, both parent roles and spouse roles as they are affected by having young children in the family.
- Increasing family member problem-solving skills.
- Increasing parental knowledge of child growth and development.
- Enhancing the resilience of the community of families with young children, and the agencies, informal associations, and others that serve or support them.

Community services used in the NPSP, as well as home visitation and other clinical services, must be geared toward achieving NPSP goals for the families it serves. At a minimum, sufficient community services must be available to serve NPSP families with the reasonable expectation of meeting the NPSP goals. Although the character of community services may vary with the installation, *community services must be available to address each of the following areas:*

1. Parenting Education.

Parenting education includes information on child growth and development, enhancing an infant's or child's physical and psychosocial environment, and effective discipline strategies appropriate to the age and disposition of the child. Community services that educate parents can meet any or all of the NPSP goals.

In planning parenting education services, it is important to consider a variety of delivery mechanisms and penetration rates. For example, parenting classes can be particularly useful to parents who are poised for the learning and can attend consistently. Historically, parenting classes reach a very small proportion of the parents needing such education. So if parenting classes are your community's desired delivery mechanism,

Consider additional efforts, such as

- educational newsletters sent to NPSP participants,
- a series of articles or regular advice column in the base newspaper, or
- periodic education opportunities for parents that address their education needs, such as a "Parent University" day that features education for parents of young children.

Newsletters are very popular with new parents. When parents are integral to the development of this resource and are provided access to information relevant to families

with children 0-3, a newsletter can facilitate connections between the parents formal agencies and community resources, as well as connection among the parents themselves. A newsletter for dads offering child care tips and skills information, child development information, nurturing ideas, “no kidding information” bits, and a question and answer section can be a key resource for new dads. A list of classes , or baby help resources to help dads become familiar with community sources for information and help.

2. Parent-child Interaction Groups.

Many bases have found parent-child interaction groups, such as “A Time for Us” or “Moms, Pops & Tots” playgroups, to be particularly effective. Unlike a “Mom’s Morning Out” activity when the parent drops off the child(ren) for a play and education experience, the parent-child interaction group requires the presence of the parent with the child throughout the session. Depending on the model, toys and activities are available by age group of the child, and parents have opportunities to interact with their children, to observe the modeling behaviors of group leaders and volunteers, to ask questions of available experts and consultants, and to socialize with other parents.

Parent-child interaction groups create opportunities for toddler socialization activities, for enhancing parenting knowledge and skills, and for building informal connections among parents, ultimately resulting in enhancing the resilience of the community of young families. Some parent-child interaction programs have parent steering groups and volunteers who take on many of the responsibilities for providing the program and may become active in developing other services for their community. Such steering groups enhance the community-resilience building opportunities in parent-child interaction groups.

3. Couples’ Communication and Problem-Solving Skills.

Some services must be available to assist couples in increasing the effectiveness of their communications, and to assist couples and single parents in developing their problem-solving skills. Developing skills involves providing education, modeling new skills and creating opportunities for participants to practice these skills. To be effective in serving NPSP participants, these services must be responsive to the issues, role confusion and role conflict that often occur when families adjust to the needs of their infants and young children.

Generally, skill-building activities require a group setting to create practice opportunities. It is important to consider the scope of services and delivery mechanisms (e.g., series of classes v. one-day training), and the likely penetration rates associated with each. These decisions must reflect unique base factors and population preferences, for example, where young families live and whether they would come to classes at the end of the duty day or the early evening when parenting responsibilities are significant.

4. Parent Support.

Parents of young children are constantly “on call” to respond to their children’s needs. They are learning and mastering new roles with their children and for couples, with each other. Many have work responsibilities to juggle as well. It makes for a very busy lifestyle with, potentially, very few supports.

While we might first think of support groups in this service area, there are other community services that provide support to young parents. Feeling supported is a subjective experience. In developing parent support activities and services, it is especially important to collaborate with young parents. The parent support area is one that lends itself to highly creative programming, which makes a consistent focus on achieving NPSP goals particularly important. Of course, parent-child interaction groups can be excellent sources of support for parents. Parent support is included as a separate required NPSP community service area because parent-child interaction groups alone will not provide sufficient support to the community of young families.

Programs designed to support young parents may miss the mark if they are not sufficiently attuned to the time or other costs they may create for the very parents they are trying to serve. Support groups that are inconvenient to the schedules of young children or their working parents are unlikely to be well attended or to achieve the degree of support they intend for the parents who participate. Instead, consider activities that could help parents achieve some of their goals or tasks while experiencing the support of assistance from others and opportunities to build informal connections with their peers. For example, an activity for young families (e.g., “Christmas video greetings”) could help parents achieve some desired tasks in a very busy season while providing opportunities for parents to interact with activity sponsors and each other.

For example assisting parents with establishing a child care co-op is a great way to support new parents. Insuring that they have basic child care training and understand child development issues and prevention techniques can give them enhanced skills and information to be successful with their child care sharing responsibilities. The parent’s empowerment is enhanced in setting up their plan and process for helping each other. Providing them with community resource information or leads for location resources can strengthen their capacity to support one another. It’s also important to provide your FAP contact information, and assure them of your availability.

Suggesting a phone tree to new parent support program participants can be most helpful. The telephone tree can be a vehicle that allows them to forge connections, address issues, or celebrate and build on strengths. New parents can phone each other for help, advice, and information, to exchange problem solving solutions, or just to chat and encourage one another. The NPSP team can consider a quarterly conference call with groups of ten or less to answer shared (frequently asked) questions, to provide information or to offer agency support.

D. ENTRY INTO THE NPSP

Families enter NPSP from three primary avenues, OB Orientation, referrals from unit leadership or other helping agencies or self-referral. Regardless of the referral source, entry begins with completion of the Family Information Form, How Can We Help? Form, Family Needs Screener (FNS), referred to as the “FNS package” or “screener package”.

At OB orientation there should be time set-aside for prospective participants to complete the FNS package. It is returned to the NPSP team and scored at a later time. When a prospective participant contacts the NPSP team directly, the options are to schedule an office or home visit to complete the FNS package. Any NPSP team member can administer this instrument. It will be a primary responsibility of the FAPA/Tech to score it and arrange for the follow-up contact to offer the participant the services appropriate to their needs.

When a referral is received from a command or another agency, it may be advisable depending on the nature of the referral, to schedule a home visit to introduce the NPSP to the prospective participant. The FNS package can be completed later in the home visit or during a second home visit.

The processes involved in working with prospective participants and participants in the NPSP are outlined on the following flow sheet, Figure D-1.

Narrative for NPSP Flow Chart

- This narrative is a companion to the NPSP flow chart.
- Initial contact with prospective participants may be made at OB orientation when they complete the Family Information Form, How Can We Help? Form and the Family Needs Screener (FNS) package. Prospective participants may call the FAP office (or be contacted by NPSP staff) and scheduled for an appointment to complete the FNS package. Or, medical providers, unit leadership or other family service providers may refer clients to the FAP due to identified risk factors in the family. Nurses and social workers should consider all available information when creating the plan to proceed with assessment of the family’s needs. When a perspective participant appears to have high needs upon referral, a home visit may be their initial contact with NPSP.
- Any team member can administer the NPSP FNS package to prospective and active participants.
- The NPSP FNS is scored primarily by the FAPA. Elevated FNS scores or areas of concern are given to FAN/FATM for review. Low FNS scores identified by the

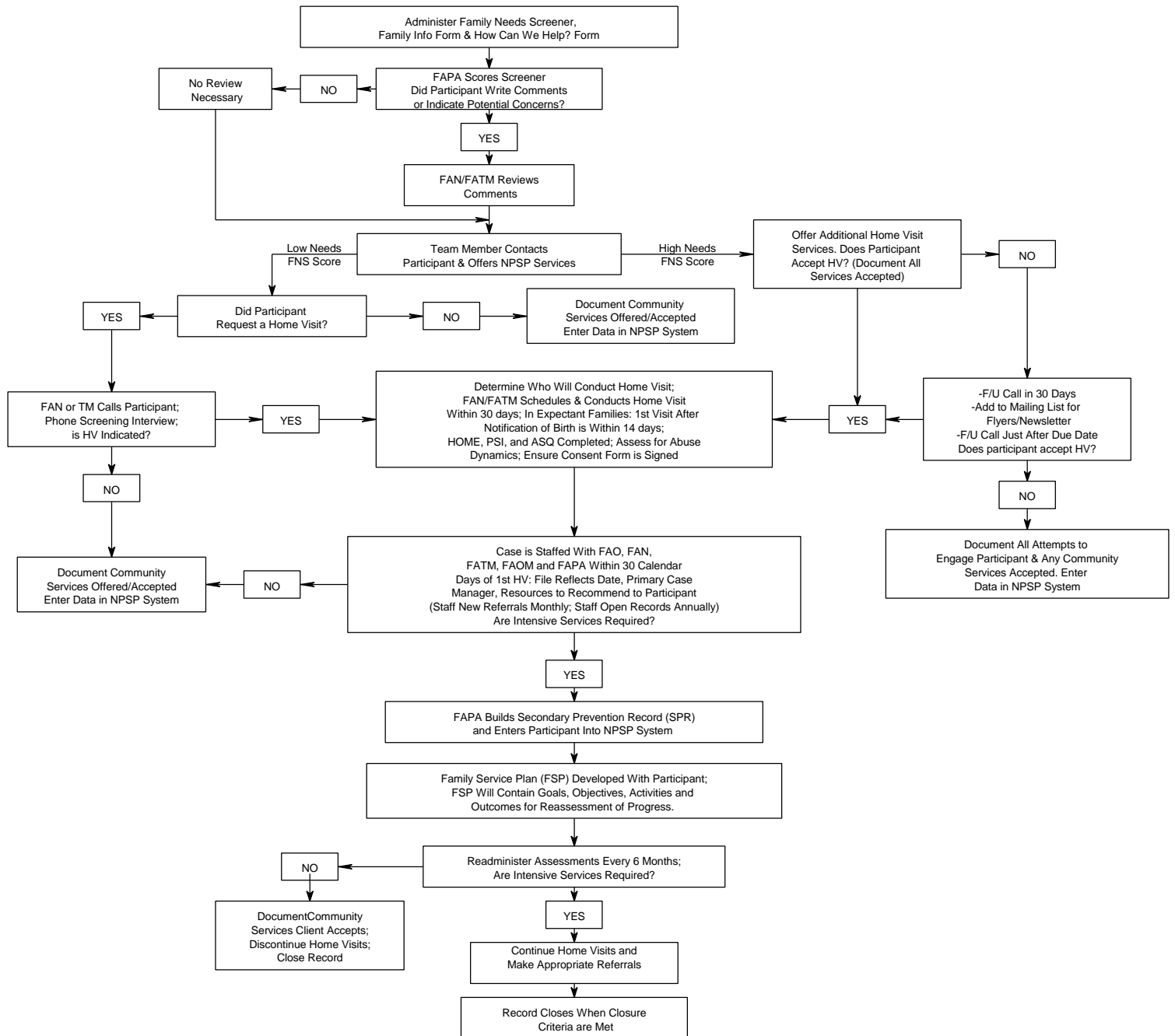
FAPA as having any written comments or areas of concern will also be given to FAN/FATM for review.

- A team member will contact the perspective participant and offer services within 30 calendar days of completing the FNS or sooner if referral information dictates, if the FNS score is 9 or higher, or if the FNS results meet additional criteria for high needs (See Table G-1), home visits and community services will be offered. If the score is less than 9, community services will be offered.
- If upon the first contact, the prospective participant refuses home visitation services, community services are offered and documented. A nurse or treatment manager makes a follow-up call in 30 days. If the prospective participant still refuses home visits, document all attempts made to engage them on the Contact Form. (See Section IVF for guidance on documentation.) If the prospective participant is pregnant, the nurse or treatment manager will attempt again to engage her in home visits after delivery of the child. If the prospective participant accepts services, determine who will make the home visit and schedule the meeting time. The timing and nature of contact with prospective participants may vary depending on the nature of the situation. See section IV-H, “Engaging Apparent ‘High Needs’ reluctant participants.”
- For low FNS scores, document all community services offered. (i.e. mailer, classes). If a low needs participant requests a home visit, a follow-up phone call will be made by a FAN/FATM to determine the need for a home visit. No more than two home visits may be offered to a participant unless:
 - The NPSP provider’s assessment is that there is risk of maltreatment and the family has high needs, and
 - The participant completes, as a minimum, the FNS, Family Information Form and Informed Consent Form.
- During First Home Visit: Nurse/Social Worker interview should further confirm or deny the FNS results. Use of the PSI, ASQ, and HOME are integral to the clinical assessment. The provider must assess for abuse and other high needs dynamics, and have FAP Consent Form signed. In expectant families, the first home visit after notification of birth should be conducted within 14 calendar days.
- If the FNS, PSI, or clinical interview reveals special areas of concern, additional assessment tools will be used with the permission of the participant (See Table G-1 for additional assessment tools and criteria for their use).
- Case is presented in the NPSP case staffing within 30 calendar days of first home visit. Staff each new referral when regular home visits start. Also, those families who score as low needs and request home visits should be presented to the team for a recommendation about whether to continue home visits. Recommendations from the team case staffing should be used in developing the FSP with the participant.

- If a record has been open for a year, it should be staffed to assess progress and need for further services.
 - NPSP Case Staffing Form will reflect date, primary case manager, and based on the team's review, recommendations for resources to be offered to participant. (See section IV-F for documentation guidance).
 - If the complete assessment indicates intensive services are not required, offer participant community services and end home visits.
 - If the complete assessment indicates intensive services are appropriate, continue home visits and FSP interventions.
- The Secondary Prevention Record (SPR) must be opened if the participant receives more than two home visits. Documentation on other participants, including those that received two or fewer home visits, is stapled and filed in the NPSP Contact Activity File.
 - FAPA/Tech will create and maintain the NPSP file and filing system, and enter data into the NPSP system (see section IV-F for details).
 - The Family Service Plan (FSP) is to be developed with the participant using NPSP team case staffing recommendations. For participants receiving ongoing home visits, the plan will contain goals, interventions, referrals, outcome measurements, and a timeline for reassessment of progress.
 - The NPSP provider implements the FSP. FNS and other instruments need to be re-administered every 6 months and at case closure. (See section IV-G for further guidance).
 - Record closes at participant's request or when closure criteria are met.

Figure D-1

NEW PARENT SUPPORT PROGRAM FLOW DIAGRAM



Assessing Needs and Strengths

All prospective participants in the NPSP complete the Family Needs Screener (FNS), a questionnaire developed for the Air Force NPSP by Dr. Glenda Kaufman Kantor and her team at the University of New Hampshire. Each prospective participant will receive the stapled “FNS package” consisting of:

- NPSP Information Form (See Appendix C)
- “How Can We Help?” Form (See Appendix C)
- FNS Questionnaire (See Appendix D)

The FNS is designed to identify prospective participants who have or may have high needs. (See the Measurement Tools Instructions section for further information. The FNS also gives an indication of the extent of needs of a prospective family. Several questions also address individual and family strengths.

The FNS “cutting point” of a score of “9” is set so that it is likely to identify all prospective participants who have high needs. This means that the number is low enough that it may also identify some prospective participants who, (although they scored “9” or greater), do not actually have high needs. (i.e. false positives)

Thus, it is important for a NPSP clinician to make contact with all prospective participants to assess needs make informed judgements regarding the indication for and to offer intensive services (home visits, referrals) when indicated.

The NPSP clinician (FAN or FATM) will contact prospective participants who appear to have high needs to discuss the program and any potential needs. These prospective participants meet one of the following situations:

- Any of five FNS questions (items 22, 23, 54, 56 or 57) is marked “agree” or “strongly agree” or “yes;” OR
- Total FNS scores equal to or greater than “9;” OR
- Comments written on the information sheet or FNS may indicate high needs; OR
- Referring professional (first sergeant, agency personnel) indicates that family members may be at risk of maltreatment.

Based on screener scores and the initial contact with the prospective participant, the clinician decides whether a home visit is indicated. In most cases, prospective participants who score as “high needs” on the FNS (either of the first two situations above) will require home visits.

When the client is willing, a home visit is arranged for further assessment. Prospective clients with “low needs” score and no apparent risk indicators who request home visits and cannot be dissuaded may receive no more than TWO home visits unless maltreatment risk factors are found.

During initial home visits, the NPSP clinician conducts a biopsychosocial assessment focused on identified needs and potential needs. Areas to cover include:

- Participant’s perceptions of need and potential need areas
- Participant perceptions of and concerns for children (and expected children) in the family
- Pertinent family history
- Significant family health history
- Relevant family dynamics
- Participant and family strengths, such as support systems, knowledge of and willingness to use community resources, and personal and family factors that support family member growth (e.g., commitment to the family unit, consideration for and proactive response to family member needs, knowledge of family health practices).
- Participant and family vulnerabilities (e.g., stressors, alcohol and drug use, health concerns)

Home visit assessments are documented on the appropriate sections of the case staffing form in the Secondary Prevention Folder (See section IV-F).

NPSP Team Case Staffing

At the heart of the NPSP is the operation that drives this multi-disciplinary approach to family maltreatment prevention, the team case staffing. This is the first formal opportunity for outreach, nursing, treatment managers and program assistants to evaluate the particulars of each new referral for intensive services. Team members work together on services tailored to each family’s unique needs. By the close of this meeting a case manager will have been appointed to each case, the resources most beneficial to the family identified, and a plan of action developed and documented. Leading this staffing, which occurs at least monthly, is the FAO, who is responsible to insure timely and quality prevention services are reaching those families identified with high needs.

Additionally, the FAO in collaboration with the FAOM and IDS, insures that unmet needs for services, identified in the NPSP universal population, are followed up by program and resource development both on and off the installation. It is the JOINT EFFORT of these uniquely skilled professionals that yields the quality product NPSP delivers to young military families.

Developing A Family Service Plan (FSP)

As a universal program with a variety of modalities for service delivery, the NPSP team documents their recommendations for the Family Service Plan in one of two ways. Families scoring in the low needs section of the FNS, who are interested in participating in community services such as groups and classes will have their Family Service Plan documented on the lower half of the NPSP Contact Form. The top half of the NPSP Contact Form is used to document all attempts to engage prospective participants, the bottom half is the Family Service Plan which reflect those services in which the family agreed to participate. Information about contacts with prospective participants is documented on SF600S.

A second, more comprehensive Family Service Plan was designed for the families scoring in the high needs section of the FNS who accepted home visits, were assessed as high needs and accepted on-going home visits and other services. With input from the NPSP team regarding available resources to utilize, the case manager engages the family in developing the NPSP Family Service Plan. A standard FSP form is provided for documentation of this plan and the signatures of its authors, including the participant. The NPSP Logic Model requires that a direct connection exist between the NPSP goals, the family's goals and the goal-directed activities of the case manager and other NPSP team members and services. Therefore, it is important that the goals established with the family clearly fit under at least one of the broader program goals, and that all planned interactions with the family have a direct correlation to the overall goals of preventing family maltreatment and enhancing mission readiness.

Write the goals, objectives, activities and outcomes with the active involvement of the participants. Use their language and bring out what is important or meaningful for them.

Be sure to provide the family with their own copy of the FSP and review it with them often to highlight progress toward stated goals. As goals are attained, encourage them to establish new goals, celebrating even small steps toward goal accomplishment. This highly structured approach to service delivery will prove very effective and rewarding for the case manager, the family and the entire NPSP team.

Frequently families receiving intensive services will need referrals for specialized services. These could be MTF services for medical or psychological conditions, or substance abuse. They could also be referrals for assistance with additional family concerns, such as financial counseling or assistance in locating appropriate childcare. These referrals should be incorporated in the Family Service Plan.

When using the HOME and ASQ with NPSP families, the NPSP clinician may be the first provider to discover an infant or child has potential developmental delays or other physical or cognitive conditions. This will become most apparent when the infant/child scores outside of normal limits on these instruments. It is imperative that NPSP clinicians make appropriate referrals for further evaluation, as well as a referral to the Exceptional Family Member Program (EFMP) Officer. The EFMP program is established to connect special needs family members to the appropriate resources and to track them throughout the sponsor's military career, insuring appropriate resources are available, either on or off of the installation, as long as the special need exists. Once these referrals are made, the NPSP clinician can expect to continue to provide direct services to this family as a member of the multi-disciplinary team of installation and community service providers.

E. ONGOING INTENSIVE SERVICES

The Family Needs Screener (FNS), as well as the other instruments used with participants receiving intensive services were designed to be administered upon referral to NPSP, at six-month intervals and again at case closure. These tools are excellent ways to monitor the progress of NPSP families. While initial scores may not appear meaningful to the client, allowing them to see the current scores compared to the initial score may prove very effective in reinforcing the change process. Tools such as the ASQ (which is repeated each time the child reaches the next age milestone) give parents helpful information and create a historical document outlining the progress made by the child due to effective parenting and a nurturing home environment.

In addition to monitoring progress, many of the tools that accompany NPSP are useful in further evaluation of an issue that surfaces during or after the initial assessment. Use of these instruments will benefit the providers of services as well as the family, by outlining the scope of the problem and guiding the immediacy of the intervention. Providers repeat the assessment tools every six months and at case closure. This serves to insure the interventions used are accomplishing the identified goals and to employ all evidence of progress as a motivating factor in accomplishing services on the Family Service Plan.

It is also important to track participants' use of these services, their perceived availability and effectiveness for participants. This case management process will help you with your understanding of the family's needs and progress in ameliorating any problems. It will also give the team a picture of the availability and effectiveness of the referral services you use for NPSP participants.

Closure Criteria

The decision to close the Secondary Prevention Record (SPR) should be a mutual decision between the family and the NPSP intensive services team. While many unexpected circumstances could affect the date of closure, the optimal time to close is when the family has succeeded in reaching the goals of the FSP and have no other concerns that would warrant establishing new goals. It is expected that the scores from the assessment tools compiled when the case was opened and at 6-month intervals, as well as at closure, would reflect the progress the family made. These scores should support the decision to close the record. If they don't, it is recommended that the case manager present the case at the next NPSP case staffing for input on whether it is truly appropriate to close. Of course, the family could decide to terminate services at any time since they are voluntary.

A summary of the course of action with the family, the interventions, an outline of the progress made on goals and reasons for case closure should be the last entry on a SF 600 in the Secondary Prevention Record. At a glance, this summary should be sufficient to outline the presenting problems and outcomes of the case. All referrals made at case closure will be included in the discharge/closure summary with other pertinent

information that would be useful for future reference. If the family requests closure prematurely, refuses to accomplish closure assessment instruments or “disappears”, the case manager must insure that every effort is made to follow the closure protocol with the family and that all efforts are documented in the closure summary. Secondary Prevention Records are destroyed two years from the last date of contact with the family.

F. Documentation and Data Collection Processes

1. Overview

Documentation of NPSP services is crucial for several reasons:

- It helps the clinician ensure NPSP services are appropriate to family needs,
- It supports standardization of approach to providing NPSP services,
- It creates a mechanism for communication among NPSP staff concerning the assessment, ongoing contact with and services provided to a family, and
- It creates an audit trail for tracking the delivery of services and through peer review, for evaluating their quality.

NPSP clinicians will follow the guidelines of their professions when documenting NPSP services. The paraprofessional clinic support services provided by FAPAs and mental health technicians will be documented under the supervision of and with the counter-signature of the clinicians whose work they are supporting, in accordance with MTF guidelines.

A Summary of NPSP Documentation Differences from Maltreatment Interventions

Documentation of NPSP services is different from documentation of maltreatment intervention services in several respects.

- NPSP services to “high needs” families receiving ongoing intensive services, including home visits, are documented in the Secondary Prevention Record, not the traditional FAP record.
 - Secondary Prevention Records are maintained at the MTF and destroyed two years after termination of services to the family.
 - Secondary Prevention Records are transferred only at the request of the participant family *after* they have made connection with NPSP staff at their new assignment.
 - No documentation of NPSP services is made in the outpatient record with the two exceptions noted below.
 - Significant clinical observations (e.g., significant changes in family risk factors, substantive changes in suicide/homicide risk, illnesses requiring medical intervention) are documented in the Secondary Prevention Record and on SF513 and forwarded to the appropriate provider for action. Completed SF513s are filed in the outpatient record with a copy in the Secondary Prevention Record.
 - Home visits and other intensive services provided to *Active Duty members* on the Personnel Reliability Program (PRP) will be noted in the members’ outpatient records according to AFI 36-2104 and MTF guidelines. Services provided to

family members of Active Duty on PRP are NOT documented in their outpatient records.

- NPSP services to “low needs” families are documented on the NPSP contact sheet and filed with the Family Information Form, How Can We Help? Form, and Family Needs Screener in the NPSP Contact Activity File. When one or two home visits were made, the instruments given, FAP Prevention Informed Consent Form, and Case Staffing Form may also be attached to this package. These are destroyed two years after last contact with the family.
- A NPSP log is maintained to track referrals, including individuals and couples attending OB orientation who complete the initial paperwork.
- Data are collected for submission to AFMOA/SGOF using the Family Information Form, Data Summary Form, and the NPSP Monthly Report. (See Appendix H for duplication-ready copies of forms.)

2. Documentation of Participant Services

Determining the Type of Documentation to Use

The extent and type of documentation of contact with and services to NPSP participants and prospective participants depends on the scope of their needs and nature of the services provided. The decision rules are summarized in Table F-1 below. Forms and instructions are contained in this section. Instruments to use are described in Section IVG with samples and instructions in Appendix I. Duplication-ready copies of forms are in Appendix H.

A Secondary Prevention Record (SPR) is used *when a family is assessed as having “high needs,” and accepts intensive services*, such as home visits, referrals for other clinical services and community-based education and support services. (See FAP Std. P-13)

Documentation consists of a stapled package of forms (filed in the NPSP Contact Activity File) when:

- A family assessed as “high needs” declines intensive services, or
- A family is screened or assessed as “low needs.” Many of these families receive community services, and may receive no more than two home visits. Since there will not be ongoing intensive services, a SPR is not generated.

Initial Documentation

All families referred or approached to participate in the NPSP will receive a package of documentation to complete (referred to as the *FNS package* or *screener package*):

- Family Information Form (See Figure F-1)
- How Can We Help? Form (See Figure F-2)
- Family Needs Screener (See Section G for instructions, sample form and scoring)

The mother or primary caretaker completes these forms. The Family Information Form contains basic information, including contact mechanisms. The How Can We Help? Form is designed to assist the participant and NPSP staff in developing the Family Service Plan. The Family Needs Screener is used to determine which families are likely to be in need of intensive services.

Family Information Form Instructions

This form is the first in the package given to prospective participants. It is completed by the mother or primary caretaker. Items on the form are self-explanatory. The prospective participant signs acknowledgment that the information they provide will be maintained by NPSP staff in order to provide services, and may be used for evaluation of the NPSP.

How Can We Help? Form Instructions

This form is the second in the package given to prospective participants. It creates a convenient way for prospective participants to specify their areas of interest and needs. It is used in working with the participant to develop a Family Service Plan.

Figure F-1

**NEW PARENT SUPPORT PROGRAM
FAMILY INFORMATION FORM**

DATE _____

1. MOTHER LAST NAME: _____ **FIRST NAME:** _____

FATHER LAST NAME: _____ **FIRST NAME:** _____

2. TELEPHONE NUMBER: HOME: _____ **WORK:** _____

FATHER OF BABY/CHILD: HOME: _____ **WORK:** _____

3. HOME ADDRESS: _____

4. ARE YOU OR YOUR SPONSOR IN THE PERSONNEL RELIABILITY PROGRAM? YES/NO

5. ARE YOU A PREVIOUS NEW PARENT SUPPORT PROGRAM CLIENT? YES/NO

6. IF APPLICABLE, EXPECTED DUE DATE (YOU OR YOUR SPOUSE):

MOTHER'S SSN	FATHER'S SSN
FIRST TIME PARENT YES / NO	FIRST TIME PARENT YES / NO
BRANCH OF SERVICE	BRANCH OF SERVICE
MOTHER'S GRADE/RANK	FATHER'S GRADE/RANK

7. HOW DID YOU HEAR ABOUT OUR PROGRAM?

_____ **NEWSPAPER/FLYER**

_____ **OTHER HELPING AGENCY**

_____ **BASE TV/RADIO ANNOUNCEMENT (CHILD CARE CENTER, FAMILY SUPPORT, CHAPLAIN)**

_____ **UNIT COMMANDER/FIRST SERGEANT/ SUPERVISOR**

_____ **SPOUSE OR FAMILY MEMBER**

_____ **FRIEND OR NEIGHBOR**

_____ **MEDICAL PERSONNEL**

_____ **OTHER**

8. SPECIAL CONCERNS OR COMMENTS:

9. I understand the information in this package will be used to contact me and offer a family service plan to meet my family's needs. The information will be maintained by New Parent Support Program personnel under double lock. It may also be used by medical personnel to evaluate the quality of the New Parent Support Program.

SIGNATURE

Table F-1
New Parent Support Program Documentation

Families Who Screen as “Low Needs”:				
<i>Family Situation</i>	<i>Forms</i>	<i>How Used</i>	<i>How Maintained</i>	<i>Disposition</i>
A. Family screened as “low needs” and does NOT request home visits	Family Info. Form	Initial package of forms to get basic information and screen for needs	Stapled; Filed Alphabetically or by month of last contact in NPSP Contact Activity File. (Accordion file or file drawer are acceptable.) Secured by double lock system.	Maintain in secure, double-locked location apart from FAP maltreatment and EFMP records. Destroy two years after last contact with the family. (Note: family may continue to receive community services.)
	How Help? Form			
	Family Needs Screener (FNS)	Document follow-up contact with the family for community services. Family Service Plan (FSP) for families NOT receiving ongoing home visits is noted on this form.		
	Contact Form			
B. Family screened as “low needs,” WANTS home visits, & assessed as “low needs” (i.e., a “true negative”) OR assessed as “high needs” (i.e., a “false negative,” a rare case) and declines further services	Same forms as A. NPSP clinician calls family. If home visits agreed, add:	Same as A. Contact form also documents contact on possible home visit.	Same as A.	Same as A.
	Prevention Informed Consent Form	Obtain informed consent. Same as F for instruments. Document FSP and service refusal on Contact form; Document assessment on CSF (1-2 home visits MAX); instrument scores and closure on DSF. Staff with team within month.		
	HOME			
	PSI			
	ASQ			
	S-MAST, CES-D, CST, CST-PC, and IMS as indicated. (See Table 4G-1)			
	Data Summary Form (DSF) Case Staffing Form (CSF)			
C. Family screened as “low needs,” WANTS home visits, assessed as “high needs” (i.e. a “false negative”) & WANTS services	Same as F. (Below)	Same as F.	Open Secondary Prevention Record. (See F.)	Same as F.

Table F-1
New Parent Support Program Documentation

Families Who Screen as “High Needs”:				
<i>Family Situation</i>	<i>Forms</i>	<i>How Used</i>	How Maintained	<i>Disposition</i>
D. Family screened as “high needs” but refuses home visits	Same forms as A.	Same as A. Document fully and make repeat contact as indicated.	Same as A.	Same as A.
E. Family screened as “high needs” and WANTS home visits, and assessed as LOW needs (i.e., a “false positive”)	Same forms as B	Same as A.	Same as A.	Same as A.
F. Family screened as “high needs” and WANTS home visits, and assessed as HIGH needs (i.e., a “true positive”)	Same forms as B	Case staffing form documents assessment and staffing. HOME, PSI, and ASQ are part of the clinical assessment. Additional instruments are used to further assess specific needs. Make referrals for community and other services as indicated; document Family Service Plan on contact form. Put on mailing list if agreed.	Open Secondary Prevention Record, which includes forms, copies of instruments, and chronological SF600s (computer generated or hard copy, per MTF requirements).	Records are maintained in secure, double-locked location apart from traditional FAP records. At case closure, write closure note and maintain for two years, then destroy. Record may be transferred to new location only with written request from family via gaining NPSP staff.
	Family Service Plan (FSP)	Develop FSP with family. Use team input. Participant and clinician sign the form.		
	SF 600	Use to document progress notes, phone calls, and when ready, closure. If the family relocates, inform family of availability of NPSP at new location. Direct referrals may be made.		
Families who Refuse to Complete the Screener:				

Table F-1
New Parent Support Program Documentation

G. Family refused screener but there are indications of/concerns about “high needs,” accepted home visit, assessed as “low needs,” and referred to community services.	Same as B.	Family may refuse all forms. Document assessment on case staffing form and referrals on Contact form. Staff with team within one month.	Same as A.	Same as A.
H. Family refused screener but there are indications of “high needs,” accepted home visit, assessed as “high needs,” but refused intensive services.	Same as B. (NOTE: If family agrees to further services, FNS, Fam. Info Form, and Informed Consent MUST be completed. Follow C. or F. above, depending on screener outcome.)	Family may refuse all forms. Document assessment on case staffing form and refusal on Contact form. Staff with team within one month.	Same as A.	Same as A.

Figure F-2

**NEW PARENT SUPPORT PROGRAM
How Can We Help?**

To enable the NPSP Team to best meet the needs of your family, please identify those services and areas of education listed below which you are interested in.

Pregnancy Issues

- | | |
|---|---|
| <input type="checkbox"/> Fetal growth and development | <input type="checkbox"/> Prenatal bonding |
| <input type="checkbox"/> Referral to WIC | <input type="checkbox"/> Father's role |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Preparation for baby |
| <input type="checkbox"/> Pregnancy health issues | <input type="checkbox"/> Emotional changes |
| <input type="checkbox"/> Breast-feeding information | <input type="checkbox"/> Car seat selection |
| <input type="checkbox"/> Bottle feeding information | <input type="checkbox"/> Newborn care education |
| <input type="checkbox"/> Childbirth education | <input type="checkbox"/> Other |

Childhood Issues

- | | |
|--|---|
| <input type="checkbox"/> Child development | <input type="checkbox"/> Spoiling baby |
| <input type="checkbox"/> Parenting classes | <input type="checkbox"/> Calming baby |
| <input type="checkbox"/> Safety and child proofing | <input type="checkbox"/> Sudden Infant Death (SIDS) |
| <input type="checkbox"/> Discipline | <input type="checkbox"/> Infant personality |
| <input type="checkbox"/> Infant/toddler care | <input type="checkbox"/> Sleep patterns |
| <input type="checkbox"/> Child health care issues | <input type="checkbox"/> Infant Communication |
| <input type="checkbox"/> Toy selection | <input type="checkbox"/> Temper of tantrums |
| <input type="checkbox"/> Play and activities | <input type="checkbox"/> Toilet training |
| <input type="checkbox"/> Feeding | <input type="checkbox"/> Infant massage |
| <input type="checkbox"/> Parent and child support groups | <input type="checkbox"/> Other |

Family Issues

- | | |
|--|---|
| <input type="checkbox"/> Stress management | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Relationship counseling | <input type="checkbox"/> Single parenting |
| <input type="checkbox"/> Financial help | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Self-esteem issues | <input type="checkbox"/> Past childhood experiences |
| <input type="checkbox"/> Grief issues | <input type="checkbox"/> Behavioral problems |
| <input type="checkbox"/> Sibling rivalry | <input type="checkbox"/> Other |

Comments

SIGNATURE: _____ **DATE:** _____

Contact Form Instructions

Follow-up contact with prospective participants, including calls to determine the need for and to arrange home visits, is documented on the NPSP contact form. Significant details of any conversations are placed on the SF 600. When families are screened or assessed as having low needs or are assessed as having high needs but refuse further home visits, their Family Service Plans (FSP) will be documented on the Contact Form. With these families, the FSP consists only of the services offered to the family and whether they were accepted.

Use the prospective participant's responses on the How Can We Help? Form and your conversation with the individual to determine which services are appropriate for the family. Offer only those services that are likely to meet family needs. Date and initial all items entered on the contact form.

The categories of services (parenting education, parent-child interaction groups, couples communication/problem solving, parent-solving, parent services) correspond to the categories of required services (See section IV-C) and are also reported on the NPSP Monthly Report Form. Local names of available services may be added to the electronic version of the form for your base use. *Do NOT replace the names on the forms as you need these for tabulation of referrals for the monthly report.* Other referrals, such as services provided by other IDS agencies or civilian Community services other than those listed in the four core services categories, are written in on the lines provided, and tabulated and reported on the monthly report.

Figure F-3

Name _____ NPS ID # _____

**NEW PARENT SUPPORT PROGRAM
CONTACT FORM**

NUMBER OF CONTACT ATTEMPTS TO OFFER SERVICE:

<i>DATE OF ATTEMPT</i>	INITIALS OF PERSON ATTEMPTING CONTACT	TYPE OF CONTACT (PHONE OR IN-PERSON)	NOTES ON CONTACT ATTEMPTS

FAMILY SERVICE PLAN (NON-HV)

FNS Total Score _____

	<i>YES</i>	<i>NO</i>	<i>DATE</i>	<i>INITIALS</i>
OFFERED HOME VISITATION				
ACCEPTED HOME VISITATION				
COMMUNITY SERVICES OFFERED				
PARENTING EDUCATION SERVICE ACCEPTED?				
PARENT-CHILD INTERACTION GROUP ACCEPTED?				
COUPLES COMMUNICATION/ PROBLEM SOLVING SERVICES ACCEPTED?				
PARENT SUPPORT SERVICES ACCEPTED?				

May we add you to our mailing list? _____ Yes _____ No

NPS STAFF _____

Figure F-4

**FAMILY ADVOCACY INFORMED CONSENT
Prevention**

Family Advocacy prevention services are designed to strengthen and support the health and wellness of military families.

I understand that participation in the prevention program offered is completely voluntary and that I may choose to withdraw at any time without notice and without giving a reason.

I will be asked to participate in program assessment questionnaires. The data from these questionnaires will be analyzed as group data. Research findings NEVER include individual names or other identifying information.

I further understand there may be possible risks and benefits to participating. Possible risks: some questions may touch on personal or sensitive issues. Possible benefits: increased understanding of family issues and concerns, and skills in dealing with them; knowledge of health and self-care practices, and increased satisfaction with myself and other family members.

I understand that if at any time information I disclose has a bearing on my personal or my family's safety and/or medical needs, it may be necessary for you to communicate this information to a physician or appropriate Air Force personnel. In such a situation, I will be informed of the reasons for concern and the decision to relate this information.

The work of student professionals, technicians and volunteers providing services to my family is reviewed after each contact to ensure quality.

I have read this form and I fully understand benefits and risks. I agree to participate in the program.

Signature

Date

I have reviewed the information on this form with the above-identified client to ensure he/she understands FAP prevention informed consent policies.

Witness:

Documenting Home Visits and Team Case Staffings

When conducting an initial home visit, ask the participant to complete the FNS package, if not already completed. Also give the FAP Prevention Informed Consent Form to the participant for signature, addressing any questions that arise. See Figure F-4 and the Privacy Act Form (DD Form 2005).

The home visit assessment is based on a clinical interview and use of required and additional instruments (See Table G-1).

The assessment is documented on the Case Staffing Form (See Figure F-5) in the section appropriate to the NPSP clinician's profession. Date of the home visit(s) and additional observations and interventions are documented on SF 600. Ongoing home visits, contacts and referrals for other services are also recorded on SF600. Referrals are also tracked on the Case Staffing Form.

All families who screen or are assessed as "high needs" will receive a case staffing by the NPSP team. The team's recommendations for community and intensive services are made on the Case Staffing Form, which is also used to track dates of each of the follow-up team discussions of the family. The outcome of subsequent team case staffing discussions, including changes in assessments and subsequent interventions, are documented on SF 600s.

Team Case Staffing meetings are documented by producing a hard-copy agenda of the families to be discussed. Each team member attending signs the master copy of the agenda. The FAO initials each case on the agenda that is discussed. Any additional cases discussed may be written in on the master copy. The master copy of the agenda will be maintained for one year. No minutes of the meeting are produced. Team discussions and decisions will be documented, in the manner described above, only in the family's Secondary Prevention Record or the family's packet of forms filed in the NPSP Contact Activity File.

Case Staffing Form Instructions

The NPSP Case staffing form (Figure F-5) is linked to program goals focused on the prevention of family maltreatment and provides a framework and direction for NPSP staff practice and activity. It is used when high needs participants are receiving NPSP services. Page 1 is the FAN assessment and page 2 is the FATM assessment section when the FATM provides NPSP services to the participant.

The NPSP Case Staffing form is one document in which the FAN and FATM use to:

- collect data to develop a Family Service Plan.
- document collaboration on a case by the FAP NPSP multidisciplinary team.
- determine assignment of case and best practice interventions impacting NPSP program and practice outcomes.

- Record family name, ID number and initial date on which this case is staffed with the team.
- Note team members attending the initial case staffing for this family.
- Record the *Total Family Needs Screener Score*. Note whether the family scored as “high needs.” (See Table G-1 for decision rules.)
- *Referral Recommendations*: In this section note the recommendations of the team for community and intensive services. These will be used by the primary provider in working with the participant on her/his Family Service Plan.

Nursing Assessment

Nursing assessment is a key process by which the FAN collects and analyzes data to determine nursing interventions in an ongoing systematic manner. Nursing diagnosis are derived from assessment data and provides the nurse a focus for NPSP interventions. NPSP team members work together toward a common, defined goal in an outcome-based program. Data collected may include the following dimensions:

- Physical
- Psychological
- Sociocultural
- Cognitive
- Functional abilities
- Developmental
- Economic
- Lifestyle

The NPSP nursing assessment data sections and suggested areas to assess are:

- *Demographics*
 - Single parent
 - Active duty
 - Rank
 - Military unit
 - Age
 - Teenager
 - Economic status
- *Family Dynamics*
 - Family adaptation to parenthood.
 - Relationship/communication issues
 - Educational or cultural barriers
 - Family of origin
 - Single parent
 - Economic or resource needs
 - Environmental issues and safety

- Sibling issues
- History of family violence as a child
- Integration of new born into family unit
- Inexperience teen parent
- *Support Issues*
 - Knows neighbors
 - Assess for support activities or friends
 - Spouse supportive
 - Knowledge and ability to access health care and helping agencies
- *Depression/Self Esteem*
 - Assessment for evidence of post partum depression and post partum blues
 - Assess for emotional status and level of self confidence
 - Assess for level of attachment and social support
 - History of mental illness
 - Assess for unresolved grief or significant loss
 - Assess for feelings of isolation
 - Assess for evidence of low self-esteem
 - Verbal/nonverbal expression of self-esteem
 - Lack of eye contact
 - Downgrading one's self
 - Withdrawn
- *Stress/Violence*
 - Assess for abuse
 - Unwanted pregnancy
 - Keeps prenatal appointments
 - Seeks medical care
 - Single Active Duty parent
 - Spouse frequently or currently deployed
 - Relationship communication
 - Active duty spouse working long hours
 - History of child or spouse abuse
 - Child discipline practices/issues
 - Infant
 - Toddlers
 - Developmental issues
 - Inappropriate infant/child expectations
 - Lack of knowledge of child age-appropriate behavior and expectations
- *Substance History*
 - Current or history of substance abuse
 - Smoking and pregnant
- *Health Information/Background*
 - Family health issues
 - Maternal health issues
 - Infant/child health issues status

- Pre term labor
- Prenatal exposure to alcohol/smoking
- Infant / child nutritional status
 - Feeding
 - Weight and height WNL
- Infant colic behavior
- Child with history of Attention Deficit Disorder or disability
- Immunizations up to date
- *Nursing Diagnosis*
 - Determined from nursing assessment data collection
 - On going assessment
 - NPSP intervention from nursing diagnosis

Social Work Assessment

- When the New Parent Support Program staff member or team case staffing determines a social work intervention would be beneficial, a social work assessment will be done and this section of the family's Case Staffing Form completed.
- NPSP ID# and Date will be filled out at the top of page.

(NOTE: When there is more information to document than there is space to record in any of the following categories, note this on the form and continue on SF 600.)

- *Reason for Home Visit/Risk Factors*: What are the primary concerns and reasons that the NPSP team case staffing determined a social work intervention would be beneficial, for example, the wife told the FAN that her and her husband frequently argued. If known, what are the concerns and reasons for referral to the NPSP? For example, a pediatrician referred a family due to child behavior management issues. In addition, address relevant risk/need factors indicated on Family Needs Screener, and list other important information.
- *Family members present* at the time of this assessment, including children and all family members. Include non-family members that are present.
- *Pertinent Family History*, including previous MH/FAP involvement. Include family history that is gathered on assessment and on subsequent assessments. If Treatment Manager continues to work with the family then further information will be added on SF 600s. Include previous involvement with the FAP either through maltreatment referrals or other services, such as EFMP, FTP, or HOMES. Note: It may be helpful to add if they have had a positive or negative experience with FAP. This will give the team some guidance on how to work with the family.

- *Current family dynamics* to including: alliances, power struggles, power and control issues, and/or characteristics of the family. Please note if there are one or more family members who do not want to be involved in the NPSP.
- *Significant Stressors*: Include what type(s) of stress the family reports they are experiencing and what is observed/identified by the treatment manager.
- *Expectations of Children/Spouse*: What are the expectations of behavior, development, communication, and concerns of the parents with their child(ren) and with each other?
- *Mental Status*: Are the parents alert and oriented? Are they able to function in activities of daily living? Document any clinical concerns such as depression or evidence of S/H ideation or substance abuse.
- *Overall Risk Assessment*: Characterize the level of risk of maltreatment of family members based on your assessment. DSM IV diagnoses may be added if they contribute to understanding the participant's or family's issues and needs. (e.g. Major Depression.)

(NOTE: When there is more information to document than there is space to record in any of the following categories, note this on the form and continue on SF 600.)

Assessment data is used by the NPSP team to develop the Family Service Plan and to develop practice and NPSP program outcomes. This process is to be documented in the appropriate forms for the purpose of continuity of care among the NPSP team. (See Contact Form Instructions and Family Service Plan Instructions in the section.)

Discussion notes should contain those specific family issues that are important for the NPSP multidisciplinary team members to know. Appropriate referrals should be made based on the individual family's needs and documented on the case staffing form. Annotate who is the assigned case manager complete the signature block. Once the case has been staffed, the Case Staffing form will be maintained in the Secondary Prevention Record.

Figure F-5

**NPSP
CASE STAFFING FORM**

Initial Meeting Date: _____ NPSP ID #: _____
Participant Name: _____

Attending Team Members: _____

Family Needs Screener Total Score: _____

REFERRAL RECOMMENDATIONS

Classes: _____
Groups: _____
Health: _____
Counseling: _____
Community: _____
Primary Provider: _____
Review Date: _____

ADDITIONAL CASE STAFFING DATES:

NURSING ASSESSMENT

DATE OF ASSESSMENT: _____

1. Relevant Demographics: _____
2. Family Dynamics
 - Current relationship: _____
 - _____
 - Family of origin: _____
 - _____
3. Support Issues: _____
4. Depression/Self Esteem: _____
5. Stress/Violence Approval: _____
6. Substance History: _____
7. Health Background: _____
8. Nursing Diagnosis: _____
9. Discussion Notes: _____

NURSE SIGNATURE: _____

(2)

SOCIAL WORK ASSESSMENT DATE OF ASSESSMENT: _____

1. Reason for Home Visit/Risk Factors: _____

2. Family Members Present: _____

3. Pertinent Family History Including Previous MH/FAP Involvement: _____

4. Significant Stressors: _____

5. Expectations of Children/Spouse: _____

6. Current Family Dynamics: _____

7. Mental Status: _____

8. Evidence of S/H Ideations or Substance Abuse: _____

9. Date Social Work Goals/Plan Added to FSP: _____

10. Overall Risk Assessment: _____

NPSP SOCIAL WORKER SIGNATURE: _____

Family Service Plan (FSP) Form Instructions

- The FSP (Figure F-6) is completed with the participant following the initial Team Case Staffing meeting on the family, and is documented on the Family Service Plan Form. The home visitor will share the team's recommendations in working with the participant to develop the FSP.
- The four goals printed on the form are the NPSP goals listed on the logic model. *Use the boxes under each of the NPSP goals to write related specific family goals using the family's language.*
- Write the objective next to the goal using stated family interests and needs as well as the Practice Activity Sheets located in the FAN and FATM roles in Chapter V.
- Write in agreed activities for each objective selected (See Chapter V roles).
- Select outcome measurements specific to family's objectives from the Practice Activity Sheets. Please word in family-friendly terms, i.e. Parenting Index or questionnaire instead of Parenting Stress Index.
- All outcome measurements should be initialed and dated by the case manager when completed.
- Ensure client signs and dates the FSP after you are finished jointly developing it.

Periodic review and adjustment of the FSP should be completed by the case manager and participant after semi-annual re-administration of the instruments.

Figure F-6
NEW PARENT SUPPORT PROGRAM
FAMILY SERVICE PLAN

Participant Name: _____ Date: _____

Goals	Objectives	Activities	Outcomes
1. Enhance Healthy families			
2. Increase Family Member Role Adaptation			

Figure F-6 (cont.)

Goals	Objectives	Activities	Outcomes
3. Increase Problem Solving Skills			
4. Increase Knowledge of Child Growth and Development			

Date this plan will be reviewed by provider and PARTICIPANT_____

PARTICIPANT_____ PROVIDER_____

3. The Secondary Prevention Record – NPSP

Secondary prevention services, which include a biopsychosocial assessment and an intervention plan, tailored for “high needs” families, will be documented in the Secondary Prevention Record (SPR).

The Secondary Prevention Record will be established and maintained by the FAPA/Tech. The record will be stamped on the front and back “SPR - NPSP” for the New Parent Support Program. This will distinguish it from other FAP records. It will be a four-part record. For convenience, the six-part file folders currently used for Maltreatment/EFMP records may be converted to a four-part NPSP record by stapling the two inner dividers together.

The SPR will have a label on the upper left-and corner of the back section. The label will reflect the sponsor and spouse names, on the first line. The second line will have the sponsor’s complete SSAN. The third line will contain the NPSP ID number. To the right of that label will be another label with the case manager’s initials. Each new case manager will initial the record.

EXAMPLE:

Doe, John and Jane

SSN: 123-45-6789

N1999-0001

CM _____

- Part One – Label: Administration
 Family Information Form
 Contact Form
 Informed Consent Prevention Form
 Privacy Act Statement (DD Form 2005)
 Release of Information (As applicable)
- Part Two – Label: Data Collection
 Data Summary Form
 How Can We Help? Form
 Family Needs Screener, HOME Inv., PSI, ASQ
 All Other Assessment Instruments (As applicable)
- Part Three – Label: Case Management
 Contact Form
 Family Service Plan
 Case Staffing Form (Nursing Assessment; Social Work
 Assessment)
 Consult Sheet (SF 513, as applicable)
- Part Four – Label: Progress Notes (Latest on top)

SF 600s
Closure/Discharge Summary (On top)

SPR for New Parent Support Program will be destroyed two years from date of last contact with family.

Upon written request by the family, SPR-NPSP records will be transferred to the gaining installation, after the family arrives and makes contact with the NPSP at that location. NPSP staff at the gaining installation will send the participant's written records transfer request to the losing NPSP. The losing NPSP staff will make a copy of the record and forward the original to the gaining NPSP with a letter to acknowledge receipt. The gaining NPSP will endorse and return the letter of acknowledgment to the losing NPSP staff, who will then destroy the record copy.

NPSP documentation will not be made in outpatient medical records with the following exceptions.

- When there are significant clinical observations, NPSP providers will submit a referral to the participant's primary care physician on a SF 513 (consult form). The physician may refer the participant to the appropriate specialty provider.
- When an active duty member on Personnel Reliability Program status is receiving NPSP services, documentation will be placed in his or her outpatient record IAW AFT 36-2104 and MTF guidance.

4. Data Collection Processes

Data for the NPSP Monthly Report will be entered in the NPSP system supplied and uploaded monthly by the 15th day of the following month. NPSP staff may use the forms/files supplied by AFMOS/SGOF to assist them in collecting the data for the monthly report.

The Staff Daily Activity Form has not yet been automated and its use is optional. However, it is a valuable tool for tracking case management, services and resilience utilization. Data from this form is used in the NPSP monthly report form.

Data Summary Form Instructions

The Data Summary Form (Figure F-7) is designed to collect the results of all assessment instruments completed with the NPSP participant. Results should be recorded each time the instruments are administered to provide a chronological log of the changes in scores from initial assessment through case closure.

To facilitate transfer of assessment scores, the categories on the Data Summary Form directly correlate to the scores on each of the assessment instruments listed.

The Entry Category requires that the NPSP team member identify the outcomes associated with the assessment results. The choices listed correspond to the rows in Table F-1. Select the category that best reflects the level of need as well as the family's response to the offering of services.

In addition to space for the child's score, the ASQ section provides information about the range of scores that would prompt further evaluation. Comparison of the child's scores should be accomplished by the NPSP clinician as the scores are logged on the form.

The Closure Information Section is completed only when the family has received intensive services, including ongoing home visits (i.e. entry categories "C" or "F"). The NPSP team member identifies the reason for the decision to close the SPR-NPSP record. Please select the ONE category that is most appropriate for those records opened due to identification of high needs (on the FNS or other assessment process) and the family's acceptance of intensive services. (Figure F-7)

Figure F-7
NEW PARENT SUPPORT PROGRAM
DATA SUMMARY FORM

Family Name: _____	NPSP ID Number: _____
--------------------	-----------------------

Family Needs Screener *

	CATEGORY	INITIAL	6 MONTH FOLLOW-UP	6 MONTH FOLLOW-UP	CLOSURE
	DATE OF ADMINISTRATION				
	TOTAL SCORE (Items 1 through 57)				
A.	Demographics (1-13,2)				
B.	Stress (14-16;21,22)				
C.	Relationship Discord (17-20,23)				
D.	Support (24,25; 39; 45-51)				
E.	Substance Abuse (26-28)				
F.	Violence Approval (29-32)				
G.	Family-of-origin Violence and Neglect (33-38)				
H.	Self Esteem (40-44)				
I.	Depression (52-55)				
J.	Prior Family Violence (56,57)				

C. ENTRY CATEGORY:

- _____ A. Family screened as “low needs” and does not request home visits.
- B. Family screened as “low needs”, requested and received 1-2 home visits, and
1. _____ Assessed as “low needs” and referred to community services OR
2. _____ Assessed as “high needs” and refused intensive services
- _____ C. Family screened as “low needs”, requested and received home visits, assessed as “high needs” and accepted intensive services.
- _____ D. Family screened as “ high needs” but refused home visits
- _____ E. Family screened as “high needs”, accepted “home visits”, assessed as “low needs” and referred to community services
- _____ F. Family screened as “high needs”, accepted home visits, assessed as “high needs” and accepts intensive services
- _____ G. Family refused screener, but there are indications of concerns about high needs, accepted a home visit, assessed as “low needs” and referred to community services

- _____ H. Family refused screener but there are indications of high needs, accepted a home visit, assessed as “high needs” but refused intensive services

HOME VISIT MEASURES

	INITIAL	6 MONTH FOLLOW-UP	6 MONTH FOLLOW-UP	CLOSURE
DATE OF ADMINISTRATION				
CORE MEASURES⁺				
Parenting Inventory (PSI) ⁺				
Competence:				
Role Restriction:				
Attachment:				
ADDITIONAL ASSESSMENT MEASURES ⁺⁺				
Husband-Wife Conflict Scale (CTS)				
Negotiation Scale				
Psychological Aggression Scale				
Physical Assault Scale				
Parent-Child Conflict Scale (CTS-PC)				
Non-Violent Discipline Scale				
Psychological Aggression Scale				
Physical Assault Scale				
Mood Inventory (CES-D)				
Drinking Habits Inventory (S-MAST)-Self				
Summary Score:				
Quantity Frequency:				
Category:				
Drinking Habits Inventory (S-MAST)-Spouse				
Summary Score:				
Quantity Frequency:				
Category:				
Index of Marital Satisfaction (IMS)				

⁺ Required Measures

⁺⁺ Required when decision rule dictates (See NPSP Manual, Table 4G-1)

HOME Inventory ⁺

Subscale	Lowest Fourth	Middle Half	Upper Fourth	Initial	6 Month Follow-up	6 Month Follow-up	Closure
Date of Administration							
Responsivity	0-6	7-9	10-11				
Acceptance	0-4	5-6	7-8				
Organization	0-3	4-5	6				
Learning Material	0-4	5-7	8-9				
Involvement	0-2	3-4	5-6				
Variety	0-1	2-3	4-5				
Total Score	0-25	26-36	37-45				

ASQ⁺

	4 Months		6 Months		8 Months		10 Months		12 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-33.3		0-25		0-36.7		0-25		0-15.8	
Gross Motor	0-40.1		0-25		0-24.3		0-25		0-18	
Fine Motor	0-27.5		0-25		0-36.8		0-25		0-28.4	
Problems Solving	0-35		0-25		0-32.3		0-25		0-25.2	
Personal-social	0-33		0-25		0-30.5		0-25		0-20.1	

	14 Months		16 Months		18 Months		20 Months		22 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-35		0-34.5		0-35		0-36.3		0-35	
Gross Motor	0-25		0-32.3		0-25		0-36.2		0-25	
Fine Motor	0-25		0-30.6		0-25		0-39.8		0-25	
Problems Solving	0-25		0-26.9		0-25		0-29.9		0-25	
Personal-social	0-25		0-26.7		0-25		0-35.2		0-25	

	24 Months		27 Months		30 Months		33 Months		36 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-36.5		0-35		0-38.8		0-35		0-38.7	
Gross Motor	0-36		0-25		0-30.6		0-25		0-35.7	
Fine Motor	0-36.4		0-25		0-25.2		0-25		0-30.7	
Problems Solving	0-32.9		0-25		0-28.9		0-25		0-38.6	
Personal-social	0-35.6		0-25		0-36.9		0-25		0-38.7	

* Scores in this range indicate need for further evaluation

** Enter child's scores in this column

CLOSURE INFORMATION (For "C" and "F" cases only)

DATE OF CLOSURE (YYMMDD) _____

REASON: *(Check One)*

- | | |
|---|---|
| <input type="checkbox"/> MUTUALLY-AGREED GOALS MET | <input type="checkbox"/> NOT ELIGIBLE (Separated from Military) |
| <input type="checkbox"/> DECLINED FURTHER SERVICES | <input type="checkbox"/> SUBSTANTIATED MALTREATMENT |
| <input type="checkbox"/> ALL CHILDREN OVER 3 YEARS OLD | <input type="checkbox"/> LOSS OF CONTACT/FAILED TO KEEP APPOINTMENTS |
| <input type="checkbox"/> EARLY RETURN OF DEPENDENTS | <input type="checkbox"/> FETAL DEMISE/INFANT or CHILD DEATH |
| <input type="checkbox"/> PCS | |

Staff Daily Activity Form Instructions

Use of the Staff Daily Activity Form (F-8) is optional. The form is a useful tool for case and program management. Data from the form is used to complete the NPSP Monthly Report Form. The Form is completed by NPSP staff members providing community services or home visits.

For the purpose of accurately recording the provider of services, it is important that the date, name of provider and position be noted in the spaces provided.

Use the key at the bottom of the page to complete the File Types or Number Service Activity, Location of Contact, and Person Contacted columns. *Please choose only one number per participant, per column.*

The File Number reflects the NPSP family ID number. For community services provided, use "C". For services to a family with an open maltreatment record, use "M" - not the actual maltreatment case member.

For Service Activity, "One on One" refers to a clinical service provided to an individual, couple or family which is based on an assessment specific to the participant(s).

Travel Time should reflect the total time required to drive or walk to and from the location of the family, group or class to the nearest 10 minutes.

Visit Duration is the actual time spent delivering services to the participant or group, excluding travel time, to the nearest 10 minutes.

Figure F-8

**NEW PARENT SUPPORT PROGRAM
STAFF DAILY ACTIVITY FORM**

Date: _____ *Staff Name:* _____ *Position:* (circle) FAN FATM FAPA MH Tech FAO

FILE NUMBER	PARTICIPANT NAME	SERVICE ACTIVITY	CONTACT LOCATION	PERSON CONTACTED	TRAVEL TIME	VISIT DURATION	COMMENTS

FILE NUMBER	SERVICE ACTIVITY PROVIDED	LOCATION OF CONTACT	WHO CONTACTED
# = Open NPSP File	1. One-on-One (inc. couple, & families)	1=In Home	1=Mother
C = Community Participant	2. Support Group	2=Office	2=Father of Baby/Child
M = Maltreatment Client	3. Educational Class	3=Telephone Contact	3=Partner-NF
	4. Parent Child Group	4=MTF (Non-FAP Outpatient Clinic)	4=Mother & FOB/C
		5=Hospital In-Patient	5=Mother & Partner
		6= Other	

NPSP Monthly Report Instructions (Figure F-9)

Please record the base name and the month for which you are reporting the data. The data is due to SGOF not later than the 15th of each month. Therefore, you would report the data for the previous month.

General Information:

- Where available, enter the total number of births during the month in your MTF catchment area.
- Enter total number of Family Needs Screeners (FNS) completed, followed by the number of families identified by the screener as “high needs.”
 - Of those “high needs” families, enter the number of families who accepted ongoing home visits.
- Enter the number of families identified by the FNS as “low needs.”
 - Enter the number of “low needs” families who received a follow up call this month and were offered community services;
 - Followed by the number of “low needs” families who accepted community services.
 - Of the families scoring “low needs” on the FNS, enter the number who requested and received a home visit.
- Enter number of *HOME Inventories* completed this month.
- Enter number of *Parent Stress Inventories* completed this month.
- Enter number of *Ages and Stages Questionnaires* completed this month.
- Enter number of *Mood Inventories* completed this month.
- Enter number of *Resolving Couple Conflict Scales* completed this month.
- Enter number of *Resolving Parent-Child Conflict Scales* completed this month.
- Enter number of *Indexes of Marital Satisfaction* completed this month.
- Enter number of *Drinking Habits Inventories* completed this month
- Enter the number of families with open maltreatment records who received home visit(s) from the NPSP team this month.
- Enter total number of home visits provided by the FANs this month.
- Enter the total number of home visit provided by the FATMs this Month

Entry Category:

- The Entry Category requires that the NPSP team member identify the outcomes associated with the assessment results. These are the same as the entry categories listed on the Data Summary Form and in Figure F-1.
- Select the category that best reflects the FNS score, level of assessed needs (participants who received home visits only), and services accepted. ***Each new family is entered only once at the time their category is determined.***

NPSP Community Services:

Enter the total number of participants accepting referrals for each type of service. These categories reflect required types of services and other types of referrals. The first four categories are also located on the Contact Form. It will also be necessary for all NPSP staff to track referrals to these services of participants with whom they work. Thus, referrals placed on the Family Service Plan Form for Participants receiving intensive services should be included in the month in which the plan was completed. Later referrals, for example, to financial counseling, should be included in the month the referrals were made. *Count each referral in one category only, i.e., the category in which the referral service best fits.* The categories of referrals are:

- Parent Education Services
- Parent-Child Interaction Group
- Couples Communication/Problem Solving Services
- Parent Support Services
- Other IDS Agency Services
- Civilian Community Services other than the above

Intensive Services:

- Enter the total number of open NPSP cases. Cases are open if there is a current Family Service Plan specifying ongoing home visits.
- Enter the number of open records that reflect a minimum of one home visit was accomplished during the reporting month, here after referred to as “Active NPSP Case.”
 - Of those active records, enter how many received
 - One or more home visits from the FAN, but no home visits from the FATM
 - One or more home visits from the FATM, but no home visits from the FAN
 - At least one home visit from the FAN and at least one home visit from the FATM

Closures:

- SPR-NPSP records should only be opened when a family agrees to ongoing home visitation in the intensive service component of NPSP. Therefore, those are the NPSP cases we refer to when we ask for number of cases closed during this reporting month.
- Please select the category that best describes the reason the NPSP team decided to close the NPSP record. These categories are the same as those listed on the Data Summary Form.
 - **Mutually-agreed Goals Met:** Family and NPSP team agrees that the goals of the FSP have been met and no other concerns require the establishment of new goals.
 - **Declined Further Services:** Participant declines any further home visits.
 - **All Children Over 3 Years Old:** Youngest child turned three years old. (Note: If there is continued substantive risk of maltreatment and the family accepts services, services may be provided to the family as a Secondary Prevention Counseling case, according to FAP Standard P-11.)

- **Early Return of Dependents:** Family members returned to CONUS prior to sponsor's completion of tour.
- **PCS:** Family relocated due to sponsor receiving permanent change of station (PCS) orders.
- **Not Eligible:** Sponsor separated from military service.
- **Substantiated Maltreatment:** Upon referral to the FAP, due to an allegation of maltreatment, all documentation of contact with the family is made in the maltreatment file. Upon **substantiation** of the maltreatment allegation, the SPR-NPSP record will close.
- **Loss of Contact/Failed to Keep Appointments:** Participant has failed to keep several appointments or the NPSP provider cannot locate family.
- **Fetal Demise /Infant or Child Death:** Death of a fetus, infant or child and there are no other children under the age of three in the family. (Note: If there is continues substantive risk of maltreatment and the family accepts services, services may be provided to the family as a Secondary Prevention Counseling case, according to FAP Standard P-11.)

Other FAP Workload Information:

Secondary Prevention Counseling (SPC) Services to Families *AT-Risk* of Maltreatment:

- **These are services provided by FATMs on a space available basis; See Std P-11.**
- Enter number of referrals for SPC services this month.
- Enter number of clinical assessments for SPC services conducted this month.
- Enter number of ***Resolving Couple Conflict Scales (CTS)*** completed this month.
- Enter number of ***Resolving Parent-Child Conflict Scales (CTS-PC)*** completed this month.
- Enter number of ***Mood Inventories (CES-Ds)*** completed this month
- Enter number of ***Indexes of Marital Satisfaction (IMS)*** completed this month.
- Enter number of ***Drinking Habits Inventories (S-MAST)*** completed this month.
- Enter the number of open SPC (not NPSP) records on the last day of the month.
- Enter the number of active SPC records (not NPSP-- those receiving at least one home or office visit other than a class or group) on the last day of the month.
- Enter the number of SPC cases closed during the month.

Maltreatment Workload:

- Enter the total number of open maltreatment cases on the last day of the month.
- Enter the total number of active maltreatment cases on the last day of the month. (Have documentation of at least one office or home visit with a social worker, for the purpose of treatment, other than a group or class, during this reporting month.)
NOTE: It is possible that a case could be active one month and open the next (i.e., no therapy hours provided that month).
- Enter the total number of NRO cases presented to the FMCMT during the reporting month.

- Enter the total number of assessment interviews conducted during the reporting month, for the purpose of insuring victim safety, followed by referral to the appropriate service (Army, Navy or Marines); **OR** referred to another installation for disposition; **OR** referred to another agency after it was determined they are not eligible for AF FAP care. (Do not count NROs listed above in this category)

Figure F-9

NEW PARENT SUPPORT PROGRAM MONTHLY REPORT

BASE: _____ **MONTH:** _____ **YEAR:** _____

NPSP GENERAL INFORMATION

Number of NPSP referrals (not birth-related) _____
Number of ***Family Needs Screeners (FNS)*** completed this month? _____
 Number Screened as “High Needs”? _____
 Number Accepted Home Visits? _____
 Number Screened as “Low Needs”? _____
 Number Contacted? _____
 Number Accepted Community Services? _____
 Number of Home Visits to Families Screened Low Needs? _____
Number of ***HOME Inventories*** completed this month? _____
Number of ***PSIs (Parenting Index)*** completed this month? _____
Number of ***ASQs (Ages & Stages)*** completed this month? _____
Number of ***CES-Ds (Mood Inventory)*** completed this month? _____
Number of ***CTSs (Resolving Couple Conflict)*** completed this month? _____
Number of ***CTS-PCs (Resolving Parent-Child Conflict)*** completed this month? _____
Number of ***IMSS (Index of Marital Satisfaction)*** completed this month? _____
Number of ***S-MASTs (Drinking Habits Inventory)*** completed this month? _____
Number of Families with Open Maltreatment Cases Receiving Services this month? _____
Total Number of Home Visits provided by FANs _____
Total Number of Home Visits provided by FATMs _____

ENTRY CATEGORY: Enter number of new families in each category this month:

- _____ A. Families screened as “low needs” on FNS and do not request home visits.
_____ B. Families screened as “low needs” on FNS, requested and received 1-2 home visits, *and*
 1. _____ Assessed as “low needs” and referred to community services OR
 2. _____ Assessed as “high needs” and refused intensive services.
_____ C. Families screened as “low needs” on FNS, requested and received home visits, assessed as
 “high needs” and accepted intensive services.
_____ D. Families screened as “high needs” on FNS but refused home visits.
_____ E. Families screened as “high needs” on FNS, accepted “home visits”, assessed as
 “low needs” and referred to community services.
_____ F. Families screened as “high needs” on FNS, accepted home visits, assessed as
 “high needs” and accepted intensive services.
_____ G. Families refused screener, but there were indications of concerns about high needs,
 accepted an initial home visit, assessed as “low needs” and referred to community services.
_____ H. Families refused screener but there were indications of high needs, accepted an initial home
 visit, assessed as “high needs” but refused intensive services.

Figure F-9 (cont.)

NPSP COMMUNITY REFERRALS

Number of Participants who accepted referrals for:

Parent Education Services	_____
Parent-Child Interaction Group	_____
Couples Communication/Problem Solving Services	_____
Parent Support Services	_____
Other IDS Agency Services	_____
Civilian Community Services other than the above	_____

NPSP INTENSIVE SERVICES

Number of <i>Open</i> Cases Receiving Ongoing Home Visits?	_____
Number of <i>Active</i> Cases (i.e., at least one home visit during month)?	_____
Number of <i>Active</i> Cases receiving home visits from FAN only?	_____
Number of <i>Active</i> Cases receiving home visits from FATM only?	_____
Number of <i>Active</i> Cases receiving both FAN & FATM home visits?	_____

NPSP CLOSURES (Intensive Services Cases Only)

How many *Cases Closed*? _____

Of the cases closed, how many in each category below?

_____ Mutually-agreed Goals Met	_____ Not Eligible (Separated from Military)
_____ Declined Further Services	_____ Substantiated Maltreatment
_____ All Children Over 3 Years Old	_____ Loss of Contact/Failed to Keep
	_____ Appointments
_____ Early Return of Dependents	_____ Fetal Demise/Infant or Child Death
_____ PCS	

OTHER FAP WORKLOAD INFORMATION:

**Secondary Prevention Counseling (SPC) Services to Families *AT-RISK* of Maltreatment:
(Provided by FATM; See Std P-11)**

Number of referrals for SPC services this month?	_____
Number of clinical assessments for SPC services conducted this month	_____
Number of <i>Milner Questionnaires</i> (<i>Child Abuse Potential Inventory; CAP</i>) completed this month?	_____
Number of <i>CTSs</i> (<i>Resolving Couple Conflict</i>) completed this month?	_____
Number of <i>CTS-PCs</i> (<i>Resolving Parent-Child Conflict</i>) completed this month?	_____
Number of <i>CES-Ds</i> (<i>Mood Inventory</i>) completed this month?	_____
Number of <i>IMs</i> (<i>Index of Marital Satisfaction</i>) completed this month	_____
Number of <i>S-MASTs</i> (<i>Drinking Habits Inventory</i>) completed this month	_____
Number of open SPC cases (<i>NOT NPSP</i>) on last day of month?	_____
Number of active SPC cases (home or office visit during the month other than class or group)?	_____
Number of SPC cases closed during the month?	_____

Maltreatment Workload:

Number of open maltreatment cases on last day of month?	_____
Number of active maltreatment cases (office visit during the month other than class or group)?	_____
Number of NRO cases presented to FMCMT?	_____
Number of Assessment Interviews with no case disposition (referred as suspected, other than NROs)?	_____

G. NPSP Measurement Tools Instructions

A key feature of the revised NPSP is the use of a Family Needs Screener (FNS) tool to assist NPSP staff in evaluating family needs and any potential for maltreatment. Dr. Glenda Kaufman Kantor and her team at the University of New Hampshire developed the FNS especially for the AF NPSP. Additional measures are used when the screener indicates that there are potential special areas of need. All of the instruments assist the clinician in formulating a family assessment. Use of the FNS and tools at specified times in the delivery of NPSP services will also generate data essential to evaluating the NPSP. Decision rules for the use of all instruments are summarized in Table G-1.

All of the instruments described in this section are located in one of the four folders that make up Appendix I. When reading about one of the instruments please remove and examine the relevant materials from the folders.

1. The NPSP Family Needs Screener

The screener was based on an existing First-Time Parents program screening tool and the literature on risks and needs of pregnant family members and families with young children. The screener is a paper-and-pencil questionnaire that is completed by the primary caretaker, generally the mother or expectant mother. (See Appendix I for a copy of the screener and scoring sheet. See Appendix C for development information.)

The screening tool covers several areas:

- Demographics (Items 1-13)
- Stress (14-16, 21, 22)
- Relationship discord (17-20, 23)
- Support (24-25, 39, 45-51)
- Substance abuse (26-28)
- Violence approval (29-32)
- Family of origin violence and neglect (33-38)
- Self-esteem (40-44)
- Depression (52-55)
- Prior family violence (56-57)

The screener is scored using the screener scoring sheet. There are five questions that result in a “high needs” determination if any of them are answered positively. An example is, “At times I feel out of control, like I’m losing it.” The total score is also used to give an overall level of needs. Scores that are “9” or greater indicate likely high needs and require further assessment, if the family agrees. Scores for each of the areas (or subscales) above are then computed. These subscale scores allow staff to tell the areas in which high needs are likely. Additional questionnaires are then used to assess these areas. (See “Questionnaires to Use During Home Visits,” below.)

The FNS “cutting point” of a score of “9” is set so that it is likely to identify all prospective participants who have high needs. This means that the number is set low

enough that it may also identify some prospective participants who, although they scored “9” or greater, do not actually have high needs. Thus, it is important for a NPSP clinician to make contact with these prospective participants to assess needs and strengths further and to offer intensive services (ongoing home visits, referrals) when indicated.

TABLE G-1
Summary of Decision Rules for Measures and Home Visits*

Measure	For Whom?
FNS (<i>Family Needs Screener</i>)	All referred to NPSP
NOTE: A phone call from a clinician and possible Home Visit are indicated when:	Any of FNS items # 22, 23, 54, 56, or 57 are rated “1” on the score sheet; OR the total FNS score is = or > “9”; OR there are written comments on the FNS; OR there are ten or more missing answers on the FNS; OR referring agency information indicates family members are at risk; OR participant with “low needs” score and no apparent risk indicators requests home visit and cannot be dissuaded (ONE or TWO visits only unless risk factors are found).
USE THE FOLLOWING WITH FAMILIES RECEIVING HOME VISITS:	
HOME	All primary caretakers with children aged birth to three years in the home.
PSI (<i>Parenting Index</i>)	All primary caretakers with children aged birth to three years in the home.
ASQ (<i>Ages & Stages</i>)	With parent during home visits when children are 4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, & 36 months old.
CES-D (<i>Mood Questionnaire</i>)	FNS Depression Subscale score is 1 or greater on score sheet.
CTS (<i>Resolving Couple Conflict Scale</i>)	FNS Items # 30, 31, 33, 34, 35 are scored as a 1 on score sheet OR Relationship Discord Needs subscale of one or more.
CTS-PC (<i>Resolving Parent-Child Conflict Scale</i>)	FNS Items # 29, 32, 33, 34, 35 or 37 are scored 1 on score sheet, OR PSI Competence Sub-Scale is 21 or greater, OR PSI Attachment Sub-Scale is 10 or greater, OR Role Restriction Sub-Scale is 20 or greater.
S-MAST (<i>Drinking Habits Questionnaire</i>)	FNS Substance Abuse Subscale score is 1 or greater on score sheet.
IMS (<i>Marital Satisfaction Questionnaire</i>)	FNS Relationship Discord Subscale score is 1 or greater on score sheet, OR FNS Items # 30, 31, 33, 34, or 35 are scored as a 1 on score sheet.
NOTE FOR PARTICIPANTS RECEIVING HOME VISITS: Once you use a questionnaire with a participant, repeat it every six months or at case closure, whichever comes first. EXCEPTION: Use the ASQ when children in the home are at one of the milestone ages noted (i.e., at 4, 6, 8, , 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, & 36 months. CASE CLOSURE If the questionnaires were administered within the last 60 days, use only the FNS at case closure. If case closure for intensive services (ongoing home visits) participants occurs within 60 days of initial completion of the instruments, administer only the FNS.	

* Revised 9/7/99

Using the Family Needs Screener (FNS)

- The FNS will be given to all families referred to the NPSP.
- Each prospective participant who is a primary caretaker or expectant parent will be given a stapled set of forms, called the “FNS Package” in this manual:
 - NPSP Information Form (See Section IV-F and Appendix H)
 - “How Can We Help?” Form (See Section IV-F and Appendix H)
 - FNS questionnaire (See Figure G-1 and Appendix I)
- The FNS is designed for use with groups, such as OB orientation, or with individuals in the home or office. (NOTE: It is important to collaborate with the MTF TRICARE Office to ensure access to pregnant women who will be using TRICARE services for delivery of their children.)
- It is important to ensure that family members or friends do not influence individuals completing the screener, sometimes a challenge in the home environment.
- When a prospective participant has difficulty reading the FNS, a NPSP staff member may read it to the participant (See “Basic Questionnaire Interview Rules” below for detailed guidance).
- If ten or more responses are missing contact the respondent and ask for completion of the form. This could occur during a first home visit.
- When a prospective participant does not speak English, an interpreter may be used; however, great care must be used in interpreting scores. Responses may be affected by differences in translation from original intent of the FNS or of the respondent. Additionally, the use of the FNS with other cultures has not been studied.
 - Completed screeners are referred to the NPSP clinician for review and follow-up with the prospective participant when there are written comments; **OR** any of the five screener questions (items 22,23,54,56 or 57) marked “agree” or “strongly agree” or “yes;” **OR** total scores equal to or are greater than “9”.
- NPSP clinicians will call families when referring agency information indicates that family members may be at risk of maltreatment. When the prospective participant is willing, a home visit is arranged for further assessment. The FNS package can be completed by the prospective participant during the first home visit.
- Prospective participants with “low needs” score and no apparent risk indicators who request home visits and cannot be dissuaded may receive **only ONE or TWO visits** unless maltreatment risk factors are found.
- Participants receiving intensive home services should again complete the screener every six months or at case closure, whichever comes first.

2. Questionnaires to Use during Home Visits

Required Measures:

- HOME (Home Observation for Measurement of the Environment).
- PSI (Parenting Stress Index- Subscales) (“Parenting Index”)
- ASQ (Ages & Stages Questionnaire).
 - Use with all families receiving home visits.
 - *With expectant parents*, **delay** use of these instruments until after the baby is born or child adopted.
 - The HOME and PSI are re-administered every six months or at case closure, whichever comes first. They are re-administered along with the FNS questionnaire, and any additional instruments that have been used with the participant. (See “Measures to Address Special Needs” below. The ASQ is re-administered on its own schedule.)
 - The ASQ can first be used when the infant is 4 months old. It is then used again when the child reaches age milestones at 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, & 36 months. When a family first receives home visits, start use of the ASQ for young children in the home as they reach each of the age milestones. (See description below and Appendix D.)
 - *Case Closure*: If the questionnaires were administered within the last 60 days, use only the FNS at Case Closure. If case closure for intensive service (ongoing home visits) participants occurs within 60 days of initial completion of the instruments, administer only the FNS.

Measures to Assess Special Needs:

- Use one of these instruments when the ***Family Needs Screener, interview with the parent, or Parenting Index (for the CTS-PC only)*** indicates a potential problem in the associated area, as noted below. Use as many of these measures as necessary to cover all potential high needs special areas.
- Additional measures can be used as relevant needs areas become a concern.
- Any of the measures used are then repeated every six months or at case closure, whichever comes first.
- CES-D (Center for Epidemiological Studies - Depression) (“**Mood Inventory**”): **Use if FNS Depression Needs Subscale score of 1 or more.** (i.e., If FNS questions 52 or

53 are “disagree” or “strongly disagree,” or questions 54 or 55 are “agree” or “strongly agree.”)

- CTS (Conflict Tactics Scale) (**Resolving Couple Conflict Scale**): Use if any of FNS questions 30, 31, 33, 34, 35 are scored 1 on the score sheet, or if the Relationship Discord Needs Subscale is 1 or more.
- CTS-PC (**Resolving Parent-Child Conflict Scale**): Use if any of FNS questions 29, 32, 33, 34, 35 or 37 are scored 1 on the score sheet OR if the score on any one of the three PSI subscales is elevated (i.e., PSI Competence Subscale is 21 or greater; Attachment Subscale is 10 or greater; or Role Restriction Subscale is 20 or greater).
- S-MAST (Short Version of Michigan Alcohol Screening Test) (“**Drinking Habits Inventory**”) Alcohol Consumption Patterns: If questions 26, 27 or 28 are answered “agree” or “strongly agree.” Ask the questions about the participant or partner who may have the problem. OR – Substance abuse needs subscale score of 1 or more.
- IMS (**Index of Marital Satisfaction**): Use if any of FNS questions 30, 31, 33, 34, or 35 are scored 1 on the score sheet OR if FNS Relationship Discord Needs subscale is 1 or more.

Guidelines for Administering Questionnaires

- **Do NOT give questionnaires to participants or prospective participants to take with them and return or mail back.**
- **In group settings, wait until attendees have returned the forms, or arrange for another staff member or meeting coordinator to collect the questionnaires and return them to you.**
- **When using questionnaires in the home, remain with the family member while the form is being completed.**

Using the Family Needs Screener (FNS) with Groups

The FNS is a questionnaire designed to be completed by the primary caretaker, usually the mother or expectant mother. All NPSP staff must be familiar with the Family Needs Screener (FNS) and able to use it. It is helpful to take it yourself. Think of a participant you know and answer the questions as you think the participant would answer. Then score the screener using the FNS scoring sheet. Go over it with another NPSP staff member to resolve any questions or concerns.

When using the FNS with a group, first give your overview of the local NPSP. Then explain that completing the FNS allows us to help families get the services they want and need. Explain that each person who completes the form will receive a phone call with some suggestions of what might be helpful. A sample introduction might be:

"Our New Parent Support Program helps families with small children or who are expecting babies with information, education and support activities. Some of our special services include . . . *(describe a few of the specific features of your program, such as parenting education or support groups)*. We want to get to know a bit about you and your situation so we can give you a personal plan of what might be helpful. To help us do this easily, we have a questionnaire we'd like you to fill out. After we take a look at it, we'll give you a call with some suggestions. It is possible that you might find that some of the questions are a bit personal, but all your answers are confidential (only seen by NPSP personnel who have a need to know). Your honesty will really help us serve you better. But if there is any question you don't want to answer, you can skip it. Does anyone have any questions?"

Using questionnaires with individuals at home

The purpose of the required and additional measures is to help you understand a family's needs and work with the family to develop the family service plan. The home visitor should be familiar and comfortable with all the measures in order to introduce them with ease. While the measures are a required part of the program, individual participants

always have a right not to answer specific questions or entire questionnaires if they wish. A sample introduction might sound like this:

"One of the things I'd like you to do is answer some questionnaires that we ask each parent when they come into our program. It will help me understand you and your family a bit better. You might find that some of the questions are personal, but all your answers are confidential (only seen by FAP personnel who have a need to know), and your honesty will really help us work together to develop a plan that will meet your needs. But if there is any question you don't want to answer, you can skip it. Here, let me go over them with you...

Before handing the mother the questionnaires, sit with her and quickly review the topic of each measure and the scale she will be using to give her answers. Secondly, always ask if she has any questions before she gets started.

In most cases the mother will read and complete the measures herself. As a rule, check in with the parent after 5 minutes to see if she has any questions, or generally how she's doing with it. If you sense that she's having difficulty, you may suggest that you read them to her.

When the parent is finished, or sometime before the home visitor leaves the home, scan through the questionnaires for completeness. If any items were left blank, check to see if the parent skipped them accidentally or chose not to answer them. Try to get all items answered before leaving the house. In the case of a refused item, write an "R" in the margin by that item. When scoring the instruments, treat these refused items as missing data.

Helping participants who have problems with the questionnaires:

All the measures, except the ASQ and HOME, are designed to be "self-administered" - that is, the participant reads them to herself, and circles or writes in her own answer. However, this method is not appropriate for all participants because of literacy, ability to follow the instructions, or comprehension of the questionnaires. In cases where participants appear to have problems responding to the questions, NPSP staff will offer assistance in a way that is supportive.

If literacy is not known, it is good practice to offer the parent the choice, so as not to make her uncomfortable if she can't read. For example, after you've introduced the measures to her, you may ask, "Would you like to do this by yourself, or have me do it with you?" Where differences of language or culture might make it difficult for participants to respond to the questionnaires or to home visitor questions, it is important to check out the situation sensitively and offer assistance in a positive way. An interpreter may be used when the respondent does not understand English; however, great caution should be used in interpreting scores. There is great potential for misunderstandings in the item questions or in respondent answers. Validation of the use of these instruments with other cultural groups has NOT been established.

When assisting participants with the questionnaires, begin with the first questionnaire by reading the instructions and reviewing the answer choices she will use. Do not mention the "topic" of the measure, as it is given in the instructions that will be read aloud. If instructions are not provided, then just mention the topic, such as the "mood inventory".

The following rules comprise the basic standardization protocol that must be followed when assisting participants with the questionnaires:

Basic Questionnaire Interview Rules

The manner in which you interact with the parent on the questionnaires will let her know that anything she tells you is okay, and should increase the likelihood of honest answers. Your neutral, non-judgmental manner will eliminate possible influences on her answers and give you the truest picture of her experience.

1. The interviewer must read the instructions and each item (question) word for word, exactly as it is written on the page.
2. To maintain an objective and nonjudgmental stance, the interviewer reads each question in a straightforward manner, with an even tone of voice. In addition, the interviewer should not respond, either positively or negatively, to the parent's answers. Just go to the next question.
3. The interviewer must review the possible answer choices (e.g., "agree, disagree...") after reading the introduction to each questionnaire.
4. If the parent asks what is meant by a certain item, the interviewer may NOT explain or interpret in any way what he or she thinks it means. The interviewer should respond with "whatever it means to you". *Offering to read the item again often helps too.* (If a Parent does not understand a word due to a language barrier you may suggest that they answer the best they can, or they may skip that item). After completion, please note on the form if a language problem existed. In this case, be very cautious in interpreting any results.
5. The interviewer should repeat the answer choices (except for simple Yes/No sets) every 5 items, or more often if the respondent is having difficulty.
6. These are "self-report" measures asking for the parent's perception to the item or question. The interviewer may never question the parent's response, or make any reference to having information to the contrary (for example with alcohol use).

3. Description of Required Care Measures

HOME

Description

The HOME or Home Observation for Measurement of the Environment (Bradley & Caldwell, 1979, Caldwell & Bradley, 1984) is an observational measure of the quality of the home environment as it pertains to the child (See Appendix I). A trained observer visits with the family and scores for presence/absence of a number of aspects of the home and/or parent/child interaction. There are three versions of the HOME, an infant/toddler version (45 items); a preschool-age version (55 items); and an elementary school-age version (59 items). Subscales of the infant version include the aspects of emotional and verbal responsivity, and acceptance of child's behavior. Subscales of the preschool version include the aspects of learning, language, academic stimulation, and acceptance of child's behavior. The HOME has been shown to have good measurement qualities, such as reliability and validity.

Scoring

All items are scored either "yes" or "no". All "yes" answers score one point, whereas "no" answers do not score any points. Points for each subscale are then totaled and entered into the summary table on the first page of the HOME.

Interpretation

To the right of each summary score, percentile ranges are provided which indicate scores falling in the lowest fourth, middle half, and upper fourth of the distribution. Using these as a guide, one can determine the range into which a particular family's scores fall. For example, if a score for the Learning stimulation is a 6, then this score falls into the middle half of the distribution. Scores falling into the lowest fourth are considered to be of concern and may indicate the need for intervention. (See Data Summary Form, Appendix H).

Reference

Caldwell, B.M., & Bradley, R.H. (1984). *Home Observation for the Measurement of the Environment*

Parenting Index (PSI)

Description

The original Parenting Stress Index (PSI; Abidin, 1983, 1995; Loyd & Abidin, 1985) is a 101-item self-report (typically by the mother) measure of stress in the parent-child system. The scale consists of two areas, parent and child, with seven and six subscales, respectively, for each.. For the NPSP, we selected and modified three subscales from the parent domain to assess parenting stress in NPSP participants. Only those items which were regarded as relevant and as acceptable to USAF families were retained. Items from the following scales were included: (1) Parental Attachment, (2) Role Restriction, and (3) Parental Perceived Competence. *The form may be reproduced ONLY for use in the NPSP. Report number used each month on your Monthly Report form.* (Psychological Assessment Resources, Inc. is reimbursed for each use of this instrument.)

Scoring

The PSI uses a likert-type response format (e.g., strongly disagree, disagree, agree, strongly agree) indicating the degree to which the respondent agrees with the item. See PSI scoring sheet for specific scoring instructions.

Interpretation

The scale is well-normed (i.e., participant scores can be compared to those of regular population groups) and subscale scores above the specified cutoffs can indicate the need for intervention, as well as the possible risk for abuse. Further, scores at the extreme low end are also notable as they may indicate defensive responding (giving responses which show the family as having less stress than they may actually experience). However, there are some parents who will score at the extremely low end, which indicates that they are not particularly stressed because they are extremely competent, have extensive social support, and adequate financial resources.

Competence Sub-Scale

A high score of 21 or greater indicates that parents may lack child development knowledge or have limited child management skills. High scores may be indicative of lack of acceptance and criticism from the child's other parent. In addition, high scores have been found for parents with children with physical and mental disabilities . According to Abidin, high scores suggest a need for parent education, parent support groups, and greater personal validation and emotional support for the parent.

Attachment Sub-Scale

A high score of 10 or greater may indicate the need for clinical intervention. High scores may be associated with parents who don't feel emotional closeness with the child. There

may be a cold pattern in the parent-child interaction, or an inability to empathize with the child.

Role Restriction Sub-Scale

A high score of 20 or greater may indicate the need for clinical intervention. High scores are associated with parents who experience their roles as restricting their freedom, or frustrating them in their attempts to maintain their own identity. They may feel resentment and anger towards the child or see their lives as dominated by childrearing needs.

Adapted and reproduced by special permission of the Publisher, Psychological Assessment Resources, Inc., Odessa, FL 33556, from the Parenting Stress Index by Richard R. Abidin, Ed.D., Copyright 1990 by PAR, Inc.. Further reproduction is prohibited without permission from PAR, Inc.

Reference

Abidin, R.R. (1995). *Parenting Stress Index: Third Edition*. Odessa, FL: Psychological Assessment Resources.

Ages and Stages Questionnaire

Description

The Ages & Stages Questionnaire (ASQ; Bricker, Squires, & Mounts, 1995) is a developmental screening and tracking system for identifying children (birth to 4 years) who may be at risk of developmental delay. The ASQ consists of a series of 30-item questionnaires designed for use at specific ages of the child (4, 6, 8, 10, 12, 14, 16, 18, 20, 22, 24, 27, 30, 33, & 36 months old).

Five developmental domains are assessed in the instrument: 1) gross motor, 2) fine motor, 3) communication, 4) personal-social, and 5) problem-solving. Items reflect children's everyday activities at various developmental levels and may be modified to enhance their appropriateness for children from a variety of cultural backgrounds (see *The ASQ User's Guide*).

The ASQ can be completed by any adult caretaker, but is most effective if completed by someone who is with the child on a regular basis. The second section of the questionnaire asks about general parental concerns. Although it is not scored, it serves to address any problems that the first section of the questionnaire could not identify. The ASQ is easy to administer and an excellent training video is available.

Scoring

Caretakers are asked to rate the occurrence of behavior on a three-point scale (*yes*, *sometimes*, and *not yet*), which have numbers associated. These are then scored.

Interpretation

Cut-points for each age range have been established (See Data Summary Form, Appendix H). If scores fall below the cut-point for the child's age, a referral for full developmental evaluation is recommended. A score falling below the cutoff indicates need for further evaluation, and may suggest the existence of a deficit or problem.

Reference

Bricker, Squires, & Mounts (1995). *Ages & Stages Questionnaires (ASQ): a parent-completed, child monitoring system*. Baltimore, MD: Paul H. Brooks

Description of Additional Measures

Use of these measures is required when indicated by the FNS or Parenting Index (See Table G-1).

“Mood Inventory” (CES-D)

Description

The Mood Inventory is the name given by the NPSP to The Center for Epidemiological Studies - Depression scale (CES-D; Radloff, 1978). It is a self-report 20-item measure of depressive symptoms. The respondent is asked about experience of a variety of symptoms during the past week. Item responses range along a 4-point likert-type scale from 0 (rarely or never) to 3 (most or all the time). The CES-D was developed for use in the general population, and its measurement properties have been demonstrated to be acceptable in a large number of studies.

Scoring

Four items (4,8,12,16) are reverse scored (i.e., 3 is changed to 0, 2 is changed to 1, 1 is changed to 2, and 0 is changed to 3), and then items are summed for a total score.

Interpretation

A score of 16 or higher is considered indicative of high levels of depressive symptoms and may be associated with clinical depression. The CES-D does not have any items indicating suicidality. Persons scoring 16 or higher should be assessed for suicidality and for presence of a depression disorder. Assessment of maternal depression is a key part of clinical assessment and planning with new parents. Maternal depression (beyond brief “baby blues”) is associated with disturbances in parenting, and child well-being. Depression in women is also associated with marital discord, marital violence, and substance abuse.

Reference

Radloff, L.S. (1978). The CES-D scale: A self-report depression scale for research in the general population. *Applied Psychological Measurement*, 1: 385-401.

Resolving Couple Conflict Scale (CTS)

Description

The Conflict Tactics Scale (CTS; Straus, 1979; 1990) is a 19-item self-report measure of spouse abuse consisting of three subscales: verbal reasoning (e.g., “discussed an issue calmly”), verbal aggression (e.g., “insulted or swore at partner”) and physical aggression (e.g., “pushed, grabbed or shoved partner”). Respondents to the CTS are asked to indicate the frequency with which they committed (or experienced) each of the tactics in a marital context within the past twelve months. The subscales are called “Negotiation Scale,” “Psychological Aggression Scale,” and “Physical Assault Scale.”

The CTS is used when any of the FNS items 30, 31, 33, 34, or 35 is scored a “1” OR the Relationship Discord Needs subscale is scored as a “1” or more. Two versions of the CTS are included. The one most often used will be the version where the spouse is asked about the behavior of their partner towards them. In most cases, the female participant will be responding about her husband. The CTS version concerning what the participant did to their spouse will less often be used, most frequently when it is appropriate to be completed by a husband participant.

NOTE: Both versions of the CTS use a timeframe of the past 12 months, i.e. “*How many times in the past 12 months did YOU (Spouse version: YOUR PARTNER) do any of these things?*” ***When administering the CTS as a follow up, ask the participant to respond for the time period since they last took the CTS, usually 6 month. For example, “Please answer for the time since I last gave you the questionnaire, last (MONTH, YEAR).”***

Scoring

Weighted scores are summed for each of the three subscales using the scoring sheet provided.

Interpretation

Scores of three or less on the Negotiation scale, 13 or more on the Psychological Aggression Scale, or one or more on the Physical Assault Scale indicate possible problem patterns and require further assessment.

Endorsement of items in the **minor aggression** subscale (items 11,12,13) indicates acts of aggression that could result in injury. Behaviors which occurred more than once indicate a need for further assessment and intervention.

Endorsement of items in the **severe aggression** subscale (14-19) at any frequency, indicate acts of aggression which are associated with injury, severe intimidation, and possible lethality. ***Further assessment and intervention must be provided.***

References

Straus, M.A. & Gelles, R. (eds) (1990). *Physical Violence in American Families*. New Brunswick, NJ: Transaction Publishers.

Straus, M.A. & Hamby, S.L. (1997). Measuring physical and psychological maltreatment of children with the conflict Tactics Scale. In Kaufman Kantor, G. and J.Jasinski (eds.), *Out of the Darkness: Contemporary Research Perspectives on Family Violence*. Sage.

Revolving Parent-Child Conflict (CTS-PC)

Description

In addition to husband-wife conflict behaviors, a parent-child version of the CTS (CTS-PC; Straus & Hamby, 1997) assesses nonviolent child discipline (e.g., “sent to his/her room”), as well as psychological (e.g., “shouted, yelled or screamed at him/her”) and physical aggression (e.g., “slapped him/her on the hand, arm or leg”) by parents against children. The CTS-PC items only assess the parent’s use of the behaviors towards a child. For the NPSP, use the modified, reduced version of this scale including items on the following:

- nonviolent discipline (4 items: 1,2, 5, 10);
- psychological aggression (4 items: 6, 8, 11, 13);
- physical assault (5 items: 3, 4, 7,9, 12).

NOTE: The CTS-PC uses a timeframe of the past 12 months, i.e. *“tell me whether you have: done it once in the past year, done it twice in the past year, . . . or more than 20 times in the past year.”* **When administering the CTS-PC as a follow up, ask the participant to respond for the time period since they last took the CTS-PC, usually 6 months.** For example, *“Please answer for the time since I last gave you the questionnaire, last (MONTH, YEAR).”*

Scoring

This instrument is scored using the scoring sheet provided, Weighted scores are summed for each of the three subscales.

Interpretation

Items reflecting physically abusive behaviors at the high severity end, and legally, generally regarded as child maltreatment, are omitted from this survey with the exception of the following items:

- *Any shaking of an infant, or any hitting of a child (any age) is potentially lethal or injurious.*

Findings of any psychological or physical aggression (including corporal punishment) should indicate that discussion of alternative management strategies are needed, at a minimum.

Possible failures in child management strategies and a need for further evaluation are indicated when the Non-Violent Discipline Scale is less than 36, the Psychological Aggression Score is two or more, or the Physical Assault Score is one or more. (Pay special attention to item #3 on shaking an infant.)

References

Straus, M.A. & Gelles, R. (eds.) 1990. *Physical Violence in American Families*. New Brunswick, NJ: Transaction Publishers.

Straus, M.A. & Hamby, S.L. 1997. measuring physical and psychological maltreatment of children with the Conflict Tactics Scale. In Kaufman Kantor, G. and J.Jasinski (eds.), *Out of the Darkness: Contemporary Research Perspectives on Family Violence*. Sage.

Drinking Habits Inventory

S-MAST (Items 1-13)

Description

The original MAST or Michigan Alcoholism Screening Test is a widely used and reliable 25 question instrument to screen (not diagnose) for alcoholism. The measure provided here (S-MAST) was developed and tested (by the author of the MAST) as a shortened 13-item version of the original. Kaufman Kantor has used a modified version of the MAST to assess the partner's drinking problems (e.g., asking the wife each question in regard to her husband).

Scoring

Answers are scored and summed for a maximum total of 13 points.

Interpretation

A score of 5-6+ is regarded as clinically significant, and suggestive of alcoholism. A score of 0-4 is regarded as non-alcoholic. However, based on our familiarity with the NPSP population, scores at the upper end of this lower range (4+) indicate a need for further assessment.

Alcohol Consumption Patterns (Items 14-18)

Description

Questions on typical quantity/frequency measures are commonly used in many surveys. Prior research (e.g., Kaufman Kantor) has demonstrated that both binge patterns (drinking 4-5 drinks at a time, two or three times a week) and heavy daily drinking (drinking 4-5 drinks or more at a time almost every day) is associated with an increased risk of family violence. This means that you need to assess both drinking amounts and drinking frequency.

Scoring and Interpretation

It is important to evaluate reported drinking patterns in the context of answers to the S-MAST (Items 1-13) and the presence of other stressors in the relationship as indicated by the FNS. The score is based on the reported pattern.

A finding from items 14 and 15 that a woman is drinking 4 or more drinks per occasion at least once a week is considered a heavy drinking pattern. Similar assessments are made for males but the amount is increased to 5 or more drinks at a setting.

One should also take into account whether there have been changes in drinking habits in the recent past that show a pattern of increase (for example, non-drinker or moderate social drinker becomes a heavy social drinker). This pattern may indicate possible need for further intervention and assessment.

References

Kaufman Kantor, G. & Asdigian, N. (1997). Gender differences and alcohol related spousal aggression. In R.W. Wilsnack and S.C.Wilsnack (Eds.) *Gender and Alcohol: Individual and Social Perspectives*. New Brunswick,NJ: Rutgers University Press .

Kaufman Kantor, G., and Straus, M.A. The drunken bum theory of wife-beating. *Social Problems* 34:3;213-230. June 1987. (Also digested from the original in *Brown University Digest of Addiction Theory and Application* (DATA), January 1988. Also reprinted in M.A. Straus and R. Gelles (eds.), *Physical Violence in American Families: Risk Factors and Adaptations to Violence in 8,145 Families*. Transaction Press.

Selzer, M.L., Vinokur, A., & Van Roojen, L. A self-administered Short Michigan Alcoholism Screening Test (SMAST). *Journal of Alcohol Studies*,_36(1) 117-126.

Index of Marital Satisfaction (IMS)

Description

The Index of Marital Satisfaction (IMS; Hudson, 1992) is a 25-item self-report measure of marital distress. Items tap into the extent to which an individual perceives problems in the marriage.

Scoring

Scoring involves reverse scoring 13 items. This means that items are scored in such a way that a high score on an item indicates the presence of a problem. Then one conducts a series of calculations to arrive at a score between 0 and 100.

Interpretation

Scores of 30 or greater indicate clinically significant relationship discord. Scores of 70 or greater suggest severe distress and conflict. High scores indicate the need for clinical intervention. High levels of Marital Dissatisfaction may or may not be associated with the presence of violence in the family.

Reference

Hudson, W.W. (1982). The Clinical measurement package: A field manual. Homewood, IL. Dorsey Press

H. Engaging Apparent “High Needs” Reluctant Participants

We know that historically the First-Time Parents program has been very popular in the Air Force, even helping to give the Family Advocacy Program a more “friendly face” at many locations. And yet we have the nagging concern that some of the parents most in need of our services might also be the most reluctant to accept them.

It may be that families who screen as “high needs” and refuse services represent the group at greatest risk for future maltreatment. So it is important to develop some strategies for engaging apparent “high-needs” families who are reluctant to participate. Contact with these prospective participants will be made by the NPSP nurse or social worker, depending on the nature of the family situation or concerns and the availability of resources.

The New Parent Support Program is a voluntary program and it is important to respect a parent’s decision not to participate. At the same time, some parents may wish to participate but are reluctant to agree because of concerns about privacy, the utility of the services to their particular families, or because of uncertainty about forming a helping relationship with a home visitor. Many high needs parents at risk of future maltreatment, either as victims or offenders, have not experienced a meaningful, trusting, supportive relationship with another adult, and so the possibility of such a relationship with a home visitor, while attractive, can be intensely frightening.

So how do you engage these prospective participants?

When you have a completed Family Needs Screener (FNS), and the prospective participant has scored as “high needs:”

- Even if the prospective participant completed the FNS at an OB Orientation or similar group administration and believed filling it out was a requirement, completion of the paperwork likely represents some interest in the NPSP.
- While it is important not to assume that you know the family situation by the way the screener package was completed, it is also important to review the package carefully before calling the prospective participant to get an idea of some of the key concerns or areas of needs. Note particularly any additional comments written on the forms.
- Review the Family Information Form, and How Can We Help? Form to start to get an impression of the prospective participant’s situation. If the How Can We Help? Form was completed, there is some indication of interest in the program, or at least of interest in assistance or information.
- Review the FNS and scoresheet carefully and determine the factors that led to the “high needs” score. Are they

- largely demographic, for example, a young, single active duty female currently pregnant, or
 - are there indications of relationship problems, a pessimistic outlook, lack of social support, approval of violence or alcohol abuse, or
 - are there any “automatic high needs” answers given? (Items 22, 23, 54, 56 or 57)
- Once you’ve reviewed the package and have your impressions, you are ready to contact the prospective participant (See “Contacting Apparent High-Needs Prospective Participants,” below.) It may be helpful to consult with another NPSP team member before making the call.

When you receive a referral of an apparent “high needs” prospective participant from a referral source, such as a first sergeant or another helping agency:

- First, obtain any additional information from the referring source, for example,
 - What is the reason for the referral?
 - How does the referring source know the family?
 - What can the referring source tell you about the family situation?
 - Is this referral one the referring source considers routine or high needs?
 - What types of services might be most helpful to the family?
 - Is the prospective participant/family aware of the referral? Know about the NPSP? Receptive to the referral?

Of course, there may be some situations when the referring source brings a prospective participant to the FAP office. It can be quite problematic to excuse the prospective participant for a few minutes so that you can obtain information from the referring source. Here, the need for information may be tempered with the need to start to build a trusting relationship with the prospective participant. In this situation, you might later contact the referring source for more information, having explained your plan to do this to the prospective participant and obtained permission.

- Once you’ve organized your thoughts and pinpointed any concerns, you are ready to contact the prospective participant (See Contacting Apparent High-Needs Prospective Participants, below.) It may be helpful to consult with another NPSP team member before making the call.

Contacting Apparent High-Needs Prospective Participants

- As you would with any prospective participant, start by giving a brief overview of the program with possible services appropriate to the prospective participant, based on the information you have at the time of the initial contact. Offer a home visit.
- If the prospective participant is reluctant, gently explore any concerns or questions. Share additional information about the program as indicated by the concerns raised.

- If the prospective participant still refuses a home visit, or seems reluctant, don't push it. Parents have the right to refuse services. You can use a sales person's approach of seeking concurrence on a different, apparently smaller service. For example, you could offer to drop by with some educational materials at a time convenient to the prospective participant.
- Often, additional information or show of concern will be sufficient to allay a prospective participant's concerns, and will result in program engagement.
- Other times, it will be necessary to make several contacts and offer individual services before a prospective participant will fully engage. As they can be part of developing a working relationship, these contacts should be made by the NPSP clinician who will be working with the family should they engage.
- It is critical to differentiate when additional contact furthers the development of a positive bond and when it may be perceived as harassment. *Consultation with your NPSP team is crucial in this process.* Again, the prospective participant has the right to refuse services, even when the NPSP team is very concerned that the family is much in need of services. Respectful disengagement may facilitate future contact.
- Completion of the initial package of paperwork (Family Information Form, How Can We Help? Form and Family Needs Screener) may be delayed in order to further the development of a positive relationship with a prospective participant, but there are some risks:
 - You are working with a possibly quite difficult situation with less information than you need to be effective.
 - For many participants, potentially intrusive questions and forms are more acceptable at program entry, when some more sensitive questions might be accepted as questions asked of all. Later on these questions might cause the participants to wonder why these difficult questions are arising now, when they are already known to their home visitors.
- Should the prospective participant engage in the program, at a minimum, the Family Information Form, FNS and FAP Prevention Informed Consent Form must be completed and a Secondary Prevention Record established for the family.

Working with Participants Who Are Reluctant to Fully Engage

Here are some ideas for working with reluctant participants. These suggestions are also applicable, but may not be as important, in working with those who more readily engage.

- Start with the goals and areas most important to the participant. Partialize large outcomes into small steps that are achievable and to which the participant can commit. Specify together how you'll both know that this step is achieved.

- Offer a high degree of choice in services, goals, and starting issues. Support the participant's choices. It is important not to offer choices or suggestions that you cannot support either clinically or with a commitment of your time and services. If the participant makes suggestions you cannot support, explain the concern or limitation and work with the participant to develop alternatives.
- To the extent possible, schedule home visits and activities to fit the participant's schedule and needs.
 - Ensure contact is sufficiently frequent to support development of a positive relationship.
 - Telephone contacts, written notes and attendance at community services may be interspersed between home visits.
 - Some participants will want more time between contacts, and it is important to be sensitive to the optimal therapeutic distance. At the same time, it is difficult to establish a meaningful, supportive relationship when contact is rare.

We close this section with Klein and Cnaan's (1995) recommendations to workers for forming "primary relationships" with their high-risk clients. The hallmarks of a primary relationship are meaningful dialog, empathic responsiveness, and unconditional and ongoing support. The primary relationship is based on an advocacy and empowerment approach, and enables workers to advocate for and empower their clients.

Consider the following in developing primary relationships with participants: (p. 208)

- Active listening/open dialogue with the client regarding his or her needs, expectations, wishes and dreams
- Linking the client to activities of interest . . .
- Believing in the client's potential and ability to grow
- Focusing on strengths rather than weaknesses
- Spending quality time together . . .
- Laughing *with* the client (emphasis added)
- Sharing meaningful experiences such as birthday celebrations, . . . reminiscing about childhood experiences, helping plan a vacation . . .
- Remaining nonjudgmental and respecting the client's humanity regardless of physical appearance, body odor, or behavior
- Interacting in a nonthreatening and supportive manner
- Setting flexible, realistic boundaries after a certain level of trust and respect is established
- Empathizing with clients' frustrations and pains.

Of course, it is important to communicate clearly about apparent high risk or abusive behaviors toward infants, children or spouses, but such statements should be nonjudgmental and appropriate to the context of the visit. While working with high needs, high-risk participants can be extremely challenging, it can also create real opportunities for our personal and professional growth, and for high levels of satisfaction as we see participants reach their potentials and change in quite positive ways.

Reference

Klein A. & Cnnan, R. (1995). Practice with high-risk clients. *Families in Society*, 76, 203-211

I. Engaging Fathers in the New Parent Support Program

A key and important challenge of the NPSP is to provide opportunities to actively engage fathers in their parenting role. Engaging fathers is important. The literature indicates that most child death perpetrators are male (Brewster, Nelson, Hymel, Colby, Lucas, McCanne, & Milner, 1998). Helping the male identify his role as a new father is fundamental for developing positive parenting skills and a critical factor in the prevention of child abuse. Whereas bonding and attachment with the mother begins early during pregnancy and continues through out the child's life, the male generally does not begin this process until after birth. It is very important that the "mother focus" of most home visitation programs be expanded to more successfully include the fathers.

Mercer (1998) identified four areas of concern for fathers that helping professionals should address as they interact with fathers. These are performance, family security, relationship issues, and existential fears. A Father can become anxious about the additional financial and emotional responsibilities that result from a growing family. He can be at a loss concerning the changes in his wife, family and unborn/newborn health, involvement with children and child discipline and care issues. With a new child, the shifting of focus from the father to the newborn may put him at risk for feelings of exclusion or replacement. Additionally, a new father frequently grapples with concern about his future welfare and what would become of his family should something happen to him.

NPSP and Fathers

The NPSP prevention program offers providers with a unique opportunity to intervene and support fathers in their parenting role as well as reinforce positive parent/child interaction specifically in the area of child abuse prevention.

Unique military factors, such as frequent job-required separations, great distances from extended families, and frequent moves that disrupt the establishment of social support networks, can lead to stress among young military family members. The NPSP should be an important resource to these parents by offering interventions to military families who are experiencing challenges that are magnified by these unique factors. Offering NPSP activities scheduled so that active duty fathers are able to attend and collaboration with Commanders and 1st Stg are required in order to engage fathers into the NPSP.

AF Family Advocacy Child Death Study

The Air Force FAP conducted a review of child death due to maltreatment (Brewster, Nelson, Hymel, Colby, Lucas, McCanne, & Milner, 1998). The deaths of thirty-two infants one-year of age or less, that occurred between 1989 and early 1997 were evaluated. Eighty-one percent of the perpetrators were male. Brewster et al. (1998) identified the following risk factors in the majority of deaths: perpetrator males were alone with the infant in 86% of the incidents, the event was triggered by the infant crying

in 58% of the cases, and 47% of the deaths occurred on weekends. This study provides a focus for preventionists to develop and include the fathers in child abuse prevention strategies. Programs should emphasize calming a crying fussy baby, understanding the newborn language, and the prevention of Shaken Baby Syndrome. The focus in most home visit prevention programs is centered on the mother. Interventions consist of providing them with education and information in the areas of prenatal health, newborn infant behavior, parent-infant attachment and parent-child interactions.

NPSP Interventions

Specific child abuse prevention interventions are diverse and should be tailored to family and individual needs. Examples include caring for a newborn, calming a crying fussy infant, infant attachment and bonding, nutrition, environment preparation for the infant, home safety and prevention of Shaking Baby Syndrome, and sudden infant death syndrome (SIDS) These are important areas for education and information provided by the nurse. Other important factors affecting families are psychosocial issues such as female body image and emotional changes affecting self perception and relationships with partner and family.

Helping professionals' efforts can support and facilitate effective parenting skills with families identified as at-risk for maltreatment. Recognizing fathers, as an equal parent in their interventions will boost fathers self-esteem and foster their feelings of accomplishment. Teaching them to recognize newborn behavior and language so that they are able to interpret the newborn cues can facilitate father-child bonding. Enhancing their sense of competence and reducing family stress. It is also important to include fathers when teaching infant care and provide education on the prevention of Shaken Baby Syndrome.

Another task is assisting mothers in understanding that it takes fathers longer to process the infant as a reality, which generally occurs only after they see their infants at birth. Strategies that contribute to the infant's reality for the father before birth are hearing the unborn heartbeat, seeing the unborn on ultra sound, feeling in-utero fetal movement and participating in gathering baby supplies and equipment.

One can also assure fathers that when their babies are born, they are likely to feel more involved and see their newborns as a reality. Providing special classes for fathers that creates a forum to express their concerns and fears can be very useful linkage to military and civilian community resources and support services will also help them lower their stress from being geographically separated from extended family and close friends.

The family can benefit from participating in the NPSP in several ways. Fathers can increase their positive involvement in child care, decreasing couple stress. Positive parent-child interactions can also be seen. Effective use of community agency services and connections with other young fathers and families is also crucial.

References

Brewster, A., Nelson, J., Hymel, K., Colby, D., Lucas, D., McCanne, T., & Milner, J. (1998). Victim, perpetrator, family, and incident characteristics of 32 infant maltreatment deaths in the United States Air Force. *Child Abuse & Neglect*, 22, 91-101.

Mercer, R. (1998). *Transitions to parenthood, Course 1850*. Sunnyvale, CA: Nurse Week Publishing.

CHAPTER V

FAP TEAM ROLES IN NEW PARENT SUPPORT

At most installations the New Parent Support Program (NPSP) team consists of the Nurse(s), a Treatment Manager, the Outreach Manager, a Program Assistant, and the Family Advocacy Officer, who is the team leader. A strong, productive team is the key to a successful New Parent Support Program. The characteristics of such a team are commitment, motivation, and creative problem solving and decision making. Openness, trust, and mutual respect must be reflected in daily communications among members. The timely sharing of ideas and information is vital to the provision of quality care and comprehensive service delivery.

Each member of this team brings unique and valuable skills and perspectives which are intrinsic to our multi-disciplinary approach to service delivery. This chapter outlines the specific NPSP role of each team member and the numerous opportunities in the process for interdisciplinary cross-feed and collaboration in support of our prevention families.

NPSP's greatest strength is the differences in the team member's skills and perspectives in support of the ultimate goal of prevention of family maltreatment. The NPSP team together designs and implements the installation NPSP to meet AF and DoD requirements. A significant challenge is developing services and interventions that will build the resilience of the local community in supporting its young families. It is the differences in each members' experiences and approaches that produce the rich quality of this program. Celebrate the diversity of team members and their unique skills in accomplishing the goals of NPSP.

Core Objectives of NPSP Program

The NPSP core logic model program objectives that drive program activities and interventions are:

- Decrease potential for family maltreatment.
- Enhance parent role adaptation.
- Increase problem solving skills.
- Increase knowledge of child growth and development.

Program objectives are the intended and measurable results that participants in the NPSP must strive to attain. These core program objectives provide FAP NPSP staff with a framework and focus to develop and plan NPSP interventions. All activities and interventions should be directly linked to the NPSP program goals and impact outcomes. In addition, they must also be measurable in order to determine their effectiveness of activities and interventions.

NPSP Program Activities

Practice activities are actions that facilitate participants and provider towards the program objectives. For example, if a practice objective is to have the parent calm a crying infant, activities would include teaching and identifying infant language, providing a list of the

different infant language cues and having the parent identify current infant alert state. Providers practice activities are developed for NPSP case level activity and are linked to the NPSP logic model. In the above example this activity is linked to the program objective of decrease family maltreatment. These activities also need to be tailored for program participant's family member service plan.

Practice objectives identify minimum activities and practice expectations that are centered on the core objectives of the program. For example the NPSP program objective to decrease family violence would drive practice interventions that are focused on activities such as education on positive parenting skills. At the community level, a practice objective might be building connections between families and agencies. Associated activities would include networking with informal community leaders and agency representatives.

In Chapter V, the roles of the family advocacy nurse, treatment manager, and outreach manager include Practice Activity Sheet tables that outline additional NPSP program objectives with activities.

A. NPSP Role of The Family Advocacy Officer

1. Introduction

The Family Advocacy Officer provides the leadership in the organization and delivery of services by the New Parent Support Program (NPSP) team. The FAN, FATM, FAOM and FAPA provide direct service to families participating in NPSP. The FAO promotes team building by insuring team members know their roles and have clear guidance as to how each discipline will contribute to the accomplishing the NPSP mission.

The creation of the New Parent Support Program expands each team member's range of service delivery. The prevention element is now within the "job description" of every FAP staff member, including the FAO. Marketing NPSP and provision of prevention services requires an investment and commitment from the entire Family Advocacy team.

2. Family

The FAO insures that the NPSP is a universal program for all families expecting a child and/or with children under three years of age. While intensive services are offered to families who are assessed as having "high needs," educational and supportive programs must be available for all young families. The FAO will guide the Outreach Manager and the NPSP team to ensure such programs are available by cultivating these services from other providers both on and off the installation, as well as providing them via Integrated Delivery System (IDS), which is an excellent tool for generating needed services and programs for this population. The Family Advocacy Program cannot build community and family resiliency alone. FAP staff must engage other family service providers in linking all prevention services in support of military families.

3. Team

The FAO provides leadership for the entire FAP staff as well as the NPSP team. It is critical that the FAO balance the resources required to support the maltreatment component while offering as much staff time to the prevention mission as possible. Social work intervention must be available to support NPSP clients in need of intensive services, even if only one treatment manager is assigned to the installation. This may require the FAO to "fill in" for treatment managers in a variety of ways during high volume periods. Likewise, treatment managers must be extremely flexible and willing to wear the "hats" of the maltreatment services provider and of the prevention services provider even within the same workday. Program Assistants and Mental Health Technicians will also have dual roles in maltreatment and prevention. The FAO must be aware of the range of responsibilities assigned to the FAPA/MH Tech and insure that their time is not totally consumed by maltreatment administration and reception tasks. If two are assigned to an installation, one should have the primary role as prevention FAPA/MH Tech. As always, FAPAs are not be assigned tasks associated with the Exceptional Family Member Program.

The FAO chairs NPSP case staffing meetings, which occur at least monthly. This enables all NPSP team members to receive clinical and nursing consultation at the initial assessment and intervention with a family, and as needed until the record is closed. All NPSP records remaining open for one year should be reviewed at least annually. When appropriate, the FAO will obtain additional nursing consultation from the Medical Treatment Facility (MTF) to insure appropriate guidance, peer review and supervision are provided to Family Advocacy Nurses. It is critical that the FAO insure all services a family receives, both in their home and in the community, are documented appropriately. Additionally, all high-needs families must be identified and documentation evident that every effort was made to engage them in NPSP prevention services.

It is the responsibility of the FAO to see that NPSP monthly reports to AFMOA/SGOF are completed and forwarded no later than the 10th of each month. Data contained in these reports serve to inform AFMOA/SGOF of the numbers of young families served and the percentage of young families with “high-needs”. Additionally, these reports will reflect provider workload information and other management details, which indicate the efficiency of FAP teams.

Team leadership is a key role of the FAO, regardless of the setting. The FAP staff needs support and encouragement from their leader in consistent doses. This support may take many forms, from praise for a task well done, to standing-in for a treatment manager on a home visit, to removal of “barriers” from the team’s path or “going to bat” for a staff member. This kind of nurturing and encouragement earns the FAO the team’s respect and allegiance.

4. Community

While the FAOM is the team’s technical expert in the prevention arena, the FAO remains responsible for prevention outcomes. The community and command must be aware that the NPSP exists and the populations it serves. The FAP, in collaboration with the IDS, is tasked with the development of resilient military communities in an effort to reduce family maltreatment. The FAO, as the leader of the NPSP team, is ultimately responsible for delivery of quality, universal, prevention services tailored to the needs of young families within a seamless network of community education and support programs. It will require the entire FAP team and the IDS to accomplish the ‘Building Healthy Communities’ goal of the USAF Medical Service.

B. NPSP Role of The Family Advocacy Nurse In The New Parent Support Program

Overview

1. Introduction

The FAN is a member of the FAP NPSP multidisciplinary prevention team that provides a unique nursing perspective when providing prevention services to individuals, family and the installation community. Home visits are the key modality in providing NPSP services in the New Parent Support Program. FANs community intervention activity is focused on the prevention of child abuse and family violence. The FAN's role is to build a healthy family unit and community through a multidisciplinary team effort for the purpose of preventing family maltreatment.

The FAN's role is designed to provide structured nursing interventions for families with pregnant spouses or to children age birth to three years. Role functions of the FAN are numerous, diverse and vary according to individual/family needs over time. Based on assessments of the family, the nurse collaborates with other NPSP team members and community agencies to provide appropriate service intervention and activities. These activities are dependent upon whether the family is assessed to be "high" versus "low needs". Community activities are offered to all NPSP families. Intensive in-home services are offered to those families that are assessed as high needs. All families who receive any home visits are discussed at NPSP team case staffing meetings to determine case assessment, planning and assessment of the primary case manager.

2. Family

- a. Performs nursing assessments to identify biopsychosocial needs of the family.
- b. Provides individualized health and family education based on family assessments.
 - (1) Provides training in life management skills to reduce family stressors.
 - (2) Assists family members with the major role transitions of the perinatal period and families with children 3 years of age.
 - (3) Educates the family on how to access the medical system.
- c. Identifies and enhances individual/family strengths to prevent family maltreatment.
 - (1) Educates on the dynamics of family violence to prevent maltreatment.
 - (2) Models of positive parenting practices.
 - (3) Instructs family on patient rights to ensure access to quality health care.
- d. Provides emotional support and mentoring to enhance family function.

3. Team

- a. Brings nursing knowledge and perspective to the team on :
 - (1) The perinatal period.
 - (2) Growth and developmental milestones of the newborn and toddler period.
 - (3) Maternal/child family and health and medical issues.
 - (4) Maltreatment effects on the maternal and child health during the prenatal and toddler period.
- b. Acts as a consultant on family health care issues.
- c. Collaborates and works with FAP Team to plan community interventions, providing educational services and marketing activities as time allows.
- d. Serves as an NPSP case manager.
- e. Instructs members on how to navigate the medical system to meet the needs of the family.
- f. Acts as a liaison between the family and the team.

4. Community:

- a. Participates in marketing the program to the military and civilian community.
- b. Networks with on & off base service providers to identify and access available resources for program participants..
 - (1) Assists with referrals to appropriate agencies.
 - (2) Gives information and referral as requested.
- c. Provides health education based on the needs of the community.
- d. Provides maltreatment prevention education to the community.
- e. Conducts/facilitates support groups and classes in the community

NURSING PRACTICE FAMILY ADVOCACY NURSE

The New Parent Support Program was designed to utilize a multidisciplinary team to carry out NPSP program goals which supports mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children aged birth to three years old or pregnant spouses.

The four program objectives as described in the NPSP logic model to meet program goals are:

- Decrease potential for family maltreatment.
- Enhance parent role adaptation.
- Increase problem solving skills.
- Increase knowledge of child growth and development.

The program activities to meet the objectives are:

- Home visits as the primary modality.
- Develop provider/client relationship.
- Education.
- Assessment, referral and management.
- Multidisciplinary team coordination.

Research supports that using these following practice objectives will assist in obtaining the overall program goal.

- Increase knowledge of strengths and assets as a parent.
- Enhance couple cohesion and problem solving abilities.
- Teach parents to identify and respond to the needs of their spouse and child.

NPSP activities and interventions are integrated into nursing practice which is research-based for the purpose of providing “best practice” nursing interventions. The NPSP logic model connects nursing practice interventions with program outcomes. NPSP goals and objectives are based on theoretical knowledge and serve as the foundation for practice intervention. Nursing practice must not only link with the NPSP program goals and objectives but they must also connect to the program outcomes. The FAN’s nursing

practice includes evidence of the nursing process and adherence to national nursing standards of practice. NPSP nursing practice should include the following components:

- Nursing Interventions.
- Nursing Assessment.
- Nursing Diagnosis.
- Practice Outcomes Identifications.
- Family Service Plan.
- Implementation of Plan.
- Evaluation of Practice Interventions.

The NPSP logic model identifies *core* nursing practices and activities that drive and focus nursing practice. All activity should impact and connect with the following NPSP Program objectives:

- Decrease potential for family maltreatment.
- Enhance parent role adaptation.
- Increase problem solving skills.
- Increase knowledge of child growth and development.

Nursing care of NPSP families is linked to the NPSP Logic Model which is out-come based with program goals that is focused on the prevention of family violence. The FAN is a member of the FAP NPSP team that collaborates for the purpose of integrating best practices in a comprehensive approach to meet participant and program goals. The nurse communicates with the NPSP participant, significant others, and health care providers regarding participants Family Service Plan in the provision of care.

Nursing Practice Standards

The FAN nursing practice is grounded in nursing theory and best practice cited in the research literature and American Nurses' Association. Nursing practice is guided by the following standards of care:

- *Nursing Assessment*
 - Pertinent data are collected using NPSP assessments and interviews.
- *Nursing Diagnosis*
 - Nursing diagnosis are derived from NPSP assessment data and interviews.
- *Outcome Identification*
 - Individualized to the participant.
 - Outcomes documented as measurable goals.
 - Outcomes are mutually formulated with the participant.

- Outcomes provide direction for continuity of care.
- *Planning*
 - Family service plan prescribes interventions to attain NPSP Logic Model outcomes.
 - Plan is individualized to the participant.
 - Plan is developed with the client.
 - Plan is documented on NPSP Family Service Plan.
- *Implementation*
 - The nurse case manager implements interventions.
 - Interventions are linked with the NPSP Logic Model and outcomes.
 - Interventions are documented.
- *Evaluation*
 - Evaluation of the NPSP participant's progress toward attainment of NPSP Logic Model outcomes.
 - Ongoing assessment data are used to revise diagnoses, outcomes and is documented in the Family Service Plan.

It is within this context the FAN develops Family Service Plans that establish family goals based on assessment and nursing diagnosis. Nursing assessment should reflect data collected from the Family Needs Screener, initial interview and additional NPSP instruments to determine nursing diagnosis and focus of interventions. Assessment data and nursing diagnosis are documented on appropriate NPSP forms in the secondary prevention record.

NPS Practice Goals and Activities/Interventions

1. NPSP Core Program Objective #1:

Decrease Potential for Family Maltreatment

The Healthy People 2000 initiative has identified the reduction of injuries due to violence as a major public health goal. Former Surgeon General C. Everett Koop stated that domestic violence is "an overwhelming moral, economic, and public health burden that our society can no longer bear". The Center for Disease Control and Prevention has identified child maltreatment as a critical public health problem that is in need of and amenable to prevention approaches. Researcher Mercy and colleagues identified a critical need for programs that target children at risk early in life. Research has shown most offenders who shake babies didn't realize they were harming them critically but were simply frustrated with the crying and simply reacted impulsively (Bruce; 1989; Caffey; 1972; Crowe; 1992; Milner; 1995; Showers; 1992; Tyson; 1994.) According to Olds and Henderson (1986), no single causal factor can explain maltreatment; instead, it is a series of events such as family history of abuse, child's temperament, quality of parents social supports, financial problems, and marital conflict. If maltreatment is a symptom of family dysfunction, then our task is to understand the difficulties facing the family as well as their strengths to intervene effectively. Pregnancy and parenthood represent major milestones for both men and women.

Practice Objective #1:

Educate on the risk factors relating to family maltreatment.

Education for parents is essential to ensure that children's primary caretakers have information about child development as well as skills in caring for children. Maltreatment that occurs in the first years of life can have profound effects on the subsequent development of children. These effects may include a poor sense of self and self-identity, a lack of trust in people, difficulty experiencing pleasure, a propensity for depression, fears of intimacy, and long-lasting feelings of emptiness and dependency. The quality of interactions between a parent and child is key to optimal child development. Children whose early relationships are satisfying and whose families give them a secure sense of love, support, value, and belonging feel emotionally secure and learn to view themselves as lovable, to expect positive interactions with others, and to value close relationships.

Violence during pregnancy can have significant immediate and long-term consequences. When a pregnant woman is assaulted, (Walker, 1979) two individuals are endangered - the woman herself and her unborn child. There is an increased tendency to seek help as violence escalates during pregnancy (Walker 1979). Pregnancy and childbirth are times when individuals tend to be particularly open about their feelings and eager to share their concerns and experiences (McFarlane, 1993).

Practice Activities Objective # 1: Educate on Risk Factors Relating to Family Maltreatment:

1. Teach never shake a baby:
 - a. Video - Never shake a baby, Calming the crying baby.
 - b. Model techniques to not shake a baby.
 - c. Provide handout on never shake a baby.
 - d. Explain what happens to a baby that is shaken.
 - e. Encourage parents to ensure all baby's caregivers know not to shake baby.
2. Teach impact of partner violence:
 - a. Explain the effects of violence during pregnancy on baby.
 - b. Use of empathy bell.
 - c. Expectant Dads class.
3. Assess for Abuse:
 - a. Ask questions about the relationship, use the word "hurt" instead of abused, i.e. Have you ever been in a relationship with someone who hurt you? Are you now in such a relationship?
 - b. Observe for risk factors: severe stress, absence of emotional nurturance, psychological abuse, poor conflict resolution, jealous or controlling spouse, socially isolated, substance abuse.
 - c. Ask how partner feels about pregnancy, is he supportive.
 - d. Observe interactions with partner: check for emotional abuse, controlling behavior, fear, unexplained injuries.
 - e. Provide safety plan info as needed.
 - f. Observe parent interactions with child, signs of depression in parent.
 - g. Look for unexplained physical injuries, flat affect, avoiding eye contact, turning away from parent, colicky behaviors in child.

- h. Use state and base standards on child abuse & neglect to teach parents.

Practice Outcomes:

No maltreatment referrals

Parents can state/demonstrate alternatives to calming a crying infant/child

Parent(s) will be able to demonstrate age appropriate discipline techniques

By Parent(s) report positive communication practices with family members/partner

Assessment instruments are within normal ranges

Reduction in needs on the Negative Family Needs Screener

REFERENCES

- Alexander, R.A., Sato, Y., Smith, W., & Bennett, T. (June, 1990). Incidence of Impact Trauma with Cranial Injuries Ascribed to Shaking. *American Journal of Diseases of Children*, 144, 724-726.
- Alexander, R. A., Crabbe, L., Sato, Y., Smith, W., & Bennett, T., (Jan., 1990) Serial Abuse in Children Who Are Shaken. *AJDC*, 144, 58-60.
- American Academy of Pediatrics, Shaken Baby Syndrome: Inflicted Cerebral Trauma. *Pediatrics*, 92 No.6, 872-75. (Dec., 1993)
- Brazelton, T. (Winter, 1990). Crying and Colic. *Infant Mental Health Journal*, 11, No. 4.
- Beeghly, M., Brazelton, T., Flannery, K., Nugent, J., Barrett, D., Tronick, E., (June 1995). Specificity of Preventative Pediatric Intervention Effects in Early Infancy. *Developmental and Behavioral Pediatrics*, 16, No.3.
- Blampied, N., & France, K. (Winter, 1993). A Behavioral Model of Infant Sleep Disturbance. *Journal of Applied Behavior Analysis*, 26, No.4.
- Brewster, A., Nelson, J., & Hymel K. Infanticide. *Unpublished*. (1997).
- Bruce, D., & Zimmerman, R., (Aug. 1989). Shaken Impact Syndrome. *Pediatric Annals* 18:8.
- Caffey, J. (Aug. 1972). On the Theory and Practice of Shaking Infants. *Am. Journal Of Diseased of Children*. 124:2.
- Campbell, J. (Mar./Apr., 1993). Violence as a Nursing Priority: Policy Implications. *Nursing Outlook*, 41:2.
- Campbell, J., Oliver, C., (1993). Why Battering during Pregnancy: AWHONNC *linical Issues in Perinatal and Women's Health Nursing*. *Domestic Violence*, Vol 4, number 3.
- Coody, D., Brown, M., Montgomery, D., Flynn, A., & Yetman, R. (Mar/Apr., 1994). Shaken Baby Syndrome, Identification and Prevention for Nurse Practitioners. *Pediatric Health Care*. 8:2.
- Crowe, H., & Zeskind, P., (1992) Psychophysiological and Perceptual Response to Infant Cries Varying in Pitch. *Child Abuse and Neglect*. Vol.16.

Duhaime, A., Gennarelli, T., Thibault, L., Bruce, D., Margulies, S., & Wiser, R. (Mar.1987) The Shaken Baby Syndrome. *J. Neurosurg.* Vol. 66.

Dykes, L. (1986). The Whiplash Shaken Infant Syndrome: What Has Been Learned? *Child Abuse and Neglect.* Vol. 10.

Fischer, H. (Nov., 1994). *Permanently Damaged Long Term Follow-Up of Shaken Babies. Clinical Pediatrics.*

Halpern, L., MacLean, W., & Baumeister, A. (1995), Infant Sleep-Wake Characteristics: Relation to Neurological Status and the Prediction of Developmental Outcome. *Developmental Review.* 15.

Jones, David. (1995) Parental Empathy, Emotionality, and the Potential for Child Abuse. *Child Abuse and Neglect.* 19:6.

Keener, M., Zeanah, C., & Anders, T. (1988), Infant Temperament, Sleep Organization and Nighttime Parental Interventions. *Pediatrics.* 81.

McFarlane, J., (1993). Abuse during Pregnancy: the Horrors and the Hope. *AWHONN clinical Issues in Perinatal and Women's Health Nursing. Domestic Violence,* Vol 4, number 3.

Milner, J., Halsey, L., & Fultz, J. (1995). Empathic Responsiveness and Affective Reactivity to Infant Stimuli in High and Low-Risk for Physical Child Abuse Mothers. *Child Abuse and Neglect.* 19:6.

Olds, D., Henderson, C., Chamberlin, R., Tatelbaum, R., (1986). Preventing Child Abuse and Neglect: a Randomized Trial of Nurse Home Visitation. *Pediatrics,* Vol 78, No1, July 1986.

Reece, Robert. (1993). Fatal Child Abuse and Sudden Infant Death Syndrome: Can We Tell the Difference? *APSAC Advisor.* 6:3.

Roussey, M., Bellec, S., Delahaye, M., Joubert, H., & Giraud J. (1993). Assisting Psychosocially Distressed Mothers-to-be: Primary Prevention of Child Abuse. *Child Abuse and Neglect.* 17.

Sadeh, Avi. (1994), Assessment of Intervention for Infant Night Waking: Parental Reports and Activity-Bases Home Monitoring. *J. of Consulting and Clinical Psychology* 62:1.

Showers, J. (1992). Shaken Baby Syndrome: The Problem and a Model for Prevention. *Children Today.* 21:2.

Showers, J. (1992). Don't Shake the Baby: The Effectiveness of a Prevention Program. *Child Abuse and Neglect*. Vol. 16.

Sumner, G., & Barnard, K., (1990), *Keys to Caregiving, Instructional Manual*.

Trad, P. (1993). The Therapeutic Use of Previewing to Deter Parental Abuse. *The Journal of Primary Prevention*. 13:4.

Tyson, P., & Sobschak, K. (1994). Perceptual Responses to Infant Crying after EEG Biofeedback Assisted Stress Management Training: Implications for Physical Child Abuse. *Child Abuse and Neglect*. 18:11.

Walker, I. (1979). *The Battered Woman*, New York: Harper & Row

See Practice Activity Sheet That Follows.

NPSP NURSING INTERVENTIONS
PRACTICE ACTIVITY SHEET: Objective No. 1

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives
To support mission readiness and build healthy resilient Air Force communities by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal to three years old.	<i>Decrease Potential for Family Maltreatment</i>
	Individual Practice Objective
Measurement (Outcome):	Educate on the risk factors relating to family maltreatment
No maltreatment referrals	Increase parent(s) ability to engage in positive conflict resolution
Parent(s) can state/demonstrate alternatives to calming a crying infant/child	Improve family understanding of non-violent disciplinary strategies (i.e., non-corporal)
Parent(s) will be able to demonstrate age appropriate discipline techniques	Practice Activities
By Parent(s) report positive communication practices with family members/partner	1. <i>Assess parenting skills for strengths and weaknesses.</i>
Assessment instruments are within normal ranges	2. <i>Teach to never shake a baby/child</i>
Negative Family Needs Screener reduction in needs	3. <i>Teach impact of partner violence</i>
	4. <i>Discuss views on discipline with parent(s)</i>
	5. <i>Assess for abuse (substance and maltreatment), neglect, and inform parents of legal responsibilities</i>
	6. <i>Teach positive conflict resolution skills</i>
	7. <i>Role model effective communication skills</i>
	8. <i>Information and referral</i>

Nursing Practice Objective #2: Increase parents ability to engage in positive conflict resolution

Communication between new parents frequently declines in quantity and quality, and marital conflict and disagreement increase, reflecting a need for both communication and conflict-resolution skills. The lack of support mechanisms may contribute to the parental stress and work/family conflicts reported by many parents struggling to meet current expectations of society. They can learn inappropriate ways of resolving interpersonal conflict through imitation of parental role models. Surprisingly, when children who lived in homes with nonviolent conflict were compared with children from harmonious homes, they showed the same sorts of problems as children from violent homes. Parents may need help to learn how to effectively communicate and resolve issues before they escalate into maltreatment (Herman-Staab).

Activities for objective # 2:

1. Teach positive conflict resolution skills.
2. Teach speaker/listener techniques.
3. Model effective communication skills.
4. Encourage attendance at a Prevention relationship enhancement Program. (PREP) class for couple's communication.
5. Refer to Anger management class as needed.
6. Refer to stress management as needed.

REFERENCES

- Belsky, J., Spanier, F., & Rovine, M. (1983). Stability and change in marriage across the transition to parenthood. *Journal of Marriage and the Family*, 45, 567-577.
- Belsky, J. & Cassidy, J. (1994). Attachment: theory and evidence. In M. Rutter & D. Hay (Eds), Development through Life: A handbook for clinicians (373-402). Oxford: Blackwell Scientific Publications.
- Bowlby, J. Attachment and Loss, Vol 1: Attachment. New York, Basic Books, 1963
Ainsworth, MDS: The development of infant-mother attachment. In Caldwell, BM.
- Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology*, 25, 525-531.
- Corse, S.J. , Schmid, K., & Trickett, PK (1990). Social network characteristics of mothers in abusing and nonabusing families and their relationships to parenting beliefs. *Journal of Community Psychology*, 18:44
- Egeland, B. & Stroufe, L. A. (1981). Attachment and early maltreatment. *Child Development*, 52, 44-52.
- Egeland, B., Carlson, E., & Stroufe, L.A. (1993). Resilience as a process. *Development and Psychopathology*, 5, 517-528.
- Hillard, PJA (1985). Physical abuse in pregnancy. *Obstetrics Gynecology* 66: 185-190
- Helton, A.J., McFarlane, J. & Anderson, E.T. (1987). Battered and Pregnant: A prevalence study. *American Journal of Public Health* 77, 1337-1339
- Garmezy, N., & Rutter, M. (1983). Stress, Coping, and Development in Children. New York: McGraw-Hill.
- Grove, W.R., & Peterson, C. (1980). An update on the literature on personal and marital adjustment: The effect of children and the employment of wives. *Marriage and Family Review*, 3, 63-96.

Krappner, K., Paulsen, L., & Shuetze, Y. (1982) *Infant and family development: from trials to tetrads*. Human Development 25:373-391

Lyons,-Ruth, K., Connell, D. B., Zoll, D., & Stahl, J. (1987). Infants at social risk: Relations among infant maltreatment, maternal behavior, and infant attachment behavior. *Developmental Psychology*, 23, 223-232

Miller, B., & Sollie, D. (1980). Normal stresses during the transition to parenthood. *Family Relations*, 29,459-465.

Moss,P., Bolland, G., Foxman, R. & Owen, C. (1986) Marital Relations during the transition to parenthood. *Journal of Reproductive Infant Psychology*, 4:57-67

Rapoport, R. (1963) Normal crisis, family structure and mental health. *Family Process*, 2(1)

Riciutti, HN (Eds): Review of Child Development Research, vol 3. Chicago, University of Chicago Press, 1973, p.1

Satir, V. (1967) Conjoint Family Therapy New York: Science and Behavior Books

Steffensmeier, R.H. (1982). A role model of the transition to parenthood. *Journal of Marriage and the Family*, 44, 319-334.

Stroufe, L.A. (1988). The role of infant-caregiver attachment in development. In J. Belsky & T. Nezworski (Eds.), Clinical implications of attachment (18-38). Hillside, NJ: Erlbaum.

Stroufe, L.A., Carlson, E., & Shulman, S. (1993). Individuals in relationships: Development from infancy through adolescence. In D.C. Funder, R.D. Parkes, C. Tomlinson-Keasey, & K. Widaman (Eds), *Studying lives through time: Personality and development* (315-342). Washington, DC: American Psychological Association

Valentine, Deborah (1982). Implications for individual and family mental health. *Children Today*. May/June (16- 36)

Ventura, J.N. (1987). The Stress of Parenthood Reexamined. *Family Relations*, 36, 6-29.

Walker, L. (1979) The Battered Woman, New York: Harper & Row

Practice Activity Sheet follows.

Nursing Sample Practice Activity Sheet Objective #2

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives
To support mission readiness and build healthy resilient Air Force communities by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal to three years old.	<i>Enhance Family Member Role Adaptation</i>
Measurement (Outcome):	Individual Practice Objective
Reports participation in prenatal/parenting instruction	Teach parent(s) how to effectively attach with, and nurture, their child
Observed positive bonding behaviors	Educate parent how to recognize healthy role-changes that occur within the family
Family Needs Screener – reduction in needs	Teach parent(s) to identify and respond to needs of their partner
Parenting Index – reduction in stress indicators	Practice Activities
Optional Assessment Tools are within normal ranges	<i>1. Participate in prenatal and/or parenting instruction.</i>
Parent(s) have obtained basic infant supplies prior to child's arrival; provide safe and stimulating toddler environment.	<i>2. Discuss strategies for positive infant/parent interaction</i>
Father (if present) demonstrates evidence of adjustment(s) to partner's physical/emotional changes brought on by pregnancy/parenthood	<i>3. Model interactive behaviors between child/parent</i>
Parent(s) demonstrate ability/willingness to make time for self and partner	<i>4. Provide I&R</i>

References

- Belsky, J., Spanier, F., & Rovine, M. (1983). Stability and change in marriage across the transition to parenthood. *Journal of Marriage and the Family*, 45, 567-577.
- Belsky, J. & Cassidy, J. (1994). Attachment: theory and evidence. In M. Rutter & D. Hay (Eds), *Development through Life: A handbook for clinicians* (373-402). Oxford: Blackwell Scientific Publications.
- Bowlby, J. (1963). *Attachment and Loss, Vol 1: Attachment*. New York, Basic Books.
- Carlson, V., Cicchetti, D., Barnett, D., & Braunwald, K. (1989). Disorganized/disoriented attachment relationships in maltreated infants. *Developmental Psychology*, 25, 525-531.
- Corse, S.J. , Schmid, K., & Trickett, PK (1990). Social network characteristics of mothers in abusing and nonabusing families and their relationships to parenting beliefs. *Journal of Community Psychology*, 18:44
- Egeland, B. & Stroufe, L. A. (1981). Attachment and early maltreatment. *Child Development*, 52, 44-52.
- Egeland, B., Carlson, E., & Stroufe, L.A. (1993). Resilience as a process. *Development and Psychopathology*, 5, 517-528.
- Hillard, PJA (1985). Physical abuse in pregnancy. *Obstetrics Gynecology* 66: 185-190
- Helton, A.J., McFarlane, J. & Anderson, E.T. (1987). Battered and Pregnant: A prevalence study. *American Journal of Public Health* 77, 1337-1339
- Garmezy, N., & Rutter, M. (1983). *Stress, Coping, and Development in Children*. New York: McGraw-Hill.
- Grove, W.R., & Peterson, C. (1980). An update on the literature on personal and marital adjustment: The effect of children and the employment of wives. *Marriage and Family Review*, 3, 63-96.
- Krappner, K., Paulsen, L., & Shuetze, Y. (1982) Infant and family development: from trials to tetrads. *Human Development* 25:373-391
- Lyons, -Ruth, K., Connell, D. B., Zoll, D., & Stahl, J. (1987). Infants at social risk: Relations among infant maltreatment, maternal behavior, and infant attachment behavior. *Developmental Psychology*, 23, 223-232

Miller, B., & Sollie, D. (1980). Normal stresses during the transition to parenthood. *Family Relations*, 29,459-465.

Moss,P., Bolland, G., Foxman, R. & Owen, C. (1986) Marital Relations during the transition to parenthood. *Journal of Reproductive Infant Psychology*, 4:57-67

Rapoport, R. (1963) Normal crisis, family structure and mental health. *Family Process*, 2(1)

Riciutti, HN (Eds): *Review of Child Development Research, vol 3*. Chicago, University of Chicago Press, 1973, p.1

Satir, V. (1967) *Conjoint Family Therapy*_New York: Science and Behavior Books

Steffensmeier, R.H. (1982). A role model of the transition to parenthood. *Journal of Marriage and the Family*, 44, 319-334.

Stroufe, L.A. (1988). The role of infant-caregiver attachment in development. In J. Belsky & T. Nezworski (Eds.), Clinical implications of attachment (18-38). Hillside, NJ: Erlbaum.

Stroufe, L.A., Carlson, E., & Shulman, S. (1993). Individuals in relationships: Development from infancy through adolescence. In D.C. Funder, R.D. Parkes, C. Tomlinson-Keasey, & K. Widaman (Eds), *Studying lives through time: Personality and development* (315-342). Washington, DC: American Psychological Association

Valentine, Deborah (1982). Implications for individual and family mental health. *Children Today*. May/June (16- 36)

Ventura, J.N. (1987). The Stress of Parenthood Reexamined. *Family Relations*, 36, 6-29.

Walker, L. (1979) *The Battered Woman*, New York: Harper & Row

Program Practice Objective #2: Increase Problem Solving Skills For Parent(s)

Introduction

Crisis and stressors brings increased potential for family maltreatment. McCubbins, Thompson, and Han (1997) have found that problem solving communication is a component of positive family resiliency in crisis. A family unit that has the ability to solve problem greatly increases recovery in crisis and minimizes the risk of family dysfunction.

First Practice Objective: Improve/Enhance Life Skills

(Wasik, 1990) describes problem solving as the ability to identify the problem, or situation – select a goal(s) look at the alternatives or solutions, - consider what may occur if you utilize the solution, - make a decision as to whether the solution will work, then implement the solution. Evaluation can be follow as to whether the solution was effective or another solution would be needed.

Freund et. al's research theory supports the maternal interaction, with their children increases problem-solving skills with those children. Thus improved child independence can lead to increased cognitive skills. (Freund, L. 1990) & (McGrath, Sullivan, Seifen, 1998)

In a study on economic stress and couples (Conger, Reuter, and Elden 1999), findings suggested that couples need to be able to negotiate and agree on solutions in order to deal with internal family stressors.

Research theory suggests that physically abusive parents lack interpersonal resources; i.e. parent skills, knowledge of Growth & Development, self esteem (Coohey, Braum, 1997).

Second Practice Objective: Increase Ability to Generated Options Under Stressful Conditions

Conger (1999) in a study asserts that life events and communication influence marital adjustments. Reducing stressors that create the problem decrease conflicts. (Freund L., 1990; McGrath, Sullivan, Seifer, 1995)

The link to family maltreatment is family inability to solve problem stressors. The stressors may include the lack of resources, financial distress, social isolation, parent knowledge deficits, and marital conflicts. Research has shown that the ability to solve problem from child to adulthood may diminish abuse. Research studies suggest that problem solving skills are teachable, (Conger 1999).

One of the goals of the NPSP is to support mission readiness by providing education and support to military families during pregnancy and up to three years of a child's life. By increasing the parent's ability to solve problems, and to enhance and encourage families to increase their abilities to network and utilize their community resources in order to manage crises and stress, and increase family functioning and quality of life.

Activities for Problem Solving ie:

Teach problem solving skills.

Model problem solving.

Provide opportunities for the parent to succeed.

Empower parent(s) to identify and resolve isolation/support issues.

Teach parent(s) how to access community services.

Provide information and referral.

References

- Ayers, T. S., Sandlen, I.N., West S. 6, and Roosa, M.W. (1996). A Dispositional and Situational Assessment of Children's Coping: Testing Alternative Modules of Coping. *Journal of Personality*, 64:4.
- Cochan, C. L., & Bradberry, T.N. (1997). Negative Life Events, Merit of Action , and the Longitudinal Course of Newlywed Marriage. *Journal of Personality and Social Psychology* 73, 114 -128.
- Conger, R. D., Reuter, M. A. and Elder Jr., G.H. (1999). Couple Resilience to Economic Pressure. *Journal of Personality and Social Psycholog*, 76, 54 – 71.
- Coohey, C. and Braun, N. (1997). Toward an Integrated Framework for Understanding Child Physical Abuse. *Child Abuse and Neglect*, 21 #11, 1081 – 1094.
- Creasey, G., Ottlinger, K., DeVico, K., Murray, T., Harvey, A. and Hesson-McInnis, M. (1997). Children's Affective Responses, Cognitive Appraisals, and Coping Strategies in Response to the Negative Affect of Parents and Peers. *Journal of Experimental Child Psychology*, 67, 39 – 56.
- Fagot, B. I., and Gauvain, M. (1997). Mother-Child Problem Solving. Continuity through the Early Childhood Years. *Developmental Psychology*, 33 #3, 48 – 488.
- Ford-Gilboe, M. (1997). Family Strengths, Motivation, and Resources Predictors of Health Promotion Behavior in Single Parent and Two Parent Families. *Research in Nursing and Health*, 20, 205-217.
- Freund, L. (1990). Maternal Regulation of Children's Problem Solving Behavior and It's Impact on Children's Performance. *Child Development*, 61, 113-126.
- McGrath, M. M., Sullivan, M.C., and Seifen R. (Nov, Dec 1995). Maternal Interaction Patterns and Preschool Competence in High Risk Children. *Nursing Research*, 47. #6, 309 – 316.
- McCubbin, H. I., McCubbin, M. A., Thompson, A. I., Han, S. Y., and Allen, C. T. (1997). Families Under Stress: What Makes Them Resilient. American Assimilation of Family and Consumer Sciences Commemorative Lecture, Washington D.C.
- Pasch, L. A. (1998). Social Support, Conflict and the Development of Marital Dysfunction. *Journal of Consulting and Clinical Psychology*, 68, #2, 219 – 230.
- Stein, M. T., Coleman, W. and Epstein, R. M. (1997). "We've Tried Everything and Nothing Works": Family Centered Pediatrics and Clinical Problem Solving . *Developmental and Behavioral Pediatrics*, 114 – 119.

Stratton-Webster, C. & Hammond, M. (1997). Treating Children With Early Onset Conduct Problems: A Comparison of Child and Parent Training Interventions. *Journal of Consulting and Clinical Psychology*, 65, #1, 93 – 109.

Wasik, B. H., Bryant, D. M. and Lyons, C. M. (1990). Home Visiting Procedures for Helping Families. Newbury Park, London: Sage publications, 138 – 145.

Wylie Series on Personality Process. Handbook of Infant Development, 2nd Ed, Irving B Weiner Fairleigh Dickinson University.

Nursing Sample Practice Activity Sheet Objective #3

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives
To support mission readiness and build healthy resilient Air Force communities by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal to three years old.	<i>Increase problem solving skills for parent(s)</i>
Measurement (Outcome):	Individual Practice Objective
Appropriate assessment instruments are within normal ranges (PSI)	Improve/enhance life skills
Parent(s) independently sought out appropriate services/action to resolve problem(s)	Increase ability to generate options under stressful conditions
Demonstrated ability to manage activities of daily living (life skills)	
	Practice Activities
	<i>1. Teach problem solving skills</i>
	<i>2. Model problem solving</i>
	<i>3. Provide opportunities for the parent to succeed</i>
	<i>4. Empower parent(s) to identify and resolve isolation/support issues</i>
	<i>5. Teach parent(s) how to access community services</i>
	<i>6. Provide information and referral as needed</i>

Program Objective IV: Increase Knowledge Of Growth And Development

Introduction

There is no single causal factor to explain maltreatment. One factor under research is the relationship between the parent's expectations of his or her child, and the child's true abilities. Expecting a newly cruising-about baby not to touch breakables or garbage in a bag left on the floor is more than the young toddler is capable of managing. Developmental theorists and researchers have created numerous programs to educate parents about normal child development and what to expect from their children at specific ages, hoping to prevent maltreatment and promote parent-child interaction.

First Practice Objective: Educate about age appropriate behavior

Human beings develop according to a preset plan called the **epigenetic principle**. This principle states first that personality develops according to predetermined steps that are maturationally set. Second, society is structured in a way that invites and encourages the challenges that arise at these particular times. He identified eight stages of development, which each individual proceeds through from cradle to grave. Each stage presents a crisis requiring a positive or a negative outcome. Erikson argues for a healthy balance tending more to the positive side.

The first stage is trust vs. mistrust and it is experienced during infancy. To promote a positive outcome, parents should be instructed to respond to their infant's needs in a warm, caring manner. The second stage is autonomy vs. shame or doubt. Two and three year-olds must practice their new physical skills and develop a positive sense of autonomy. Parents can help their children acquire a sense of autonomy by encouraging their children, to do what they can for themselves.

Developmental theorists and researches have agreed that these important tasks of the early years include physical and affective regulation, differentiation of affective states, formation of a secure attachment relationship, and the development of autonomy (Cicchettand Braunewald, 1984; Greenspan and Lourie, 1981). Placing maltreatment within a developmental context is critical as the needs and expectations for both parent and child vary over time and developmental stage (Stoiber and Kratochwill, 1989).

To assist parents in the recognition of age-appropriate developmental milestones, the NPSP team should educate parents using *Keys to Caregiving* and the *Ages and Stages Questionnaires*. *Keys to Caregiving* was designed to present up-to-date information about infant behavior, describe its impact on caregiving, and aid nurses in translating this knowledge to parents. Parents taught to respond more appropriately to their infant's cues report more satisfaction with their infant and increased confidence as parents (O'Donohue and Krasner, 1995). The *Ages and Stages Questionnaires* are a series of parent-completed questionnaires used to assist states with child find efforts: screen children for possible developmental delays; to focus and structure home visits; to educate parents on child development; to monitor the development of young children; and to

empower parents. Turley (1985) asserted that mothers do not innately have sufficient knowledge about their infants to understand them and build a relationship. Schmitt (1987) has stressed the fact that difficult developmental phases can be overly stressful for parents if they do not have adequate information and skills to deal with normal changes.

To promote normal growth and development, breast-feeding should be encouraged when the mother is able to manage it emotionally and support provided to the breast-feeding mother. Breast-feeding is recognized by the national pediatric, obstetric/gynecologic, and family medicine specialty societies as the preferred form of infant nutrition (Freed, Clark, Sorenson, Lohr, Cefalo, and Curtis, 1995). Human milk is made human infants and it meets all their specific nutritional requirements. It literally evolves to meet the changing needs of the baby and is the only form of nutrition needed for the first six months of life. Parents should be instructed to recognize the developmental milestones for the transition to solids. To transition to solid foods is an important and often celebrated milestone of the first year. Parents should be instructed in the developmental skills indicating readiness for solids, self-feeding, and the introduction of the cup.

Activities for objective:

1. Dr.Brazelton & Touchpoint videos.
2. What to expect books.
3. First year calendar.
4. Feeding information.
5. Infant stimulation information.
6. Ages & Stages Questionnaire.
7. Breast feeding information and support.
8. Bottle feeding information.

Second practice objective: Teach healthy lifestyle

By approaching pregnancy and early childbearing from an ecological framework, considerable leverage can be achieved in improving pregnancy outcomes (Olds, Henderson, Tatelbaum, and Chamberlin, 1986). By calling attention to the deleterious effects of certain lifestyles of the pregnant woman on fetal development, women can be helped to change those health behaviors. By improving their diet, cutting down on cigarette smoking or the use of alcohol or illegal drugs, research found mothers experienced a decrease in preterm labor and fetal growth retardation. These changes also helped mothers to appreciate the effects of their behavior on their children's well being later in life

Partner or intimate violence is a serious problem. When a pregnant woman is assaulted, two individuals are endangered. Studies indicate a link between partner violence and unintended pregnancies, late entry into prenatal care, maternal depression, and use of tobacco, alcohol, or illicit drugs (Cokkinides and Coker, 1998). Nursing research has established a link between abuse during pregnancy and low birthweight (Bullock and McFarlane, 1989; Bullock, McFarlane, Bateman, and Miller, 1989). The vulnerability of

pregnant women and their unborn children is sufficient to confirm the need to provide these women with effective treatment and prevention strategies (Helton, 1986).

Activities for objective:

1. Information on effects of drug, alcohol, and smoking to mother and fetus, child.
2. Maternal nutrition.
3. Pregnancy and exercise.
4. Prevention strategies for partner violence.

Third practice objective: Educate on health and safety issues

To reduce the risk for maltreatment and neglect parents should be involved in assessing their capacities to recognize and responding to their childrens developmental and emotional needs. Specific strategies should be provided to assist parents in increasing their sense of effectiveness in providing safe, nurturing environments for their children. Education on age-appropriate safety concerns should involve the parent in assessing safety hazards in their own home. Safe, positive parenting practices will enhance feelings of competence in their parenting roles through positive comments, empathic listening, and enabling parents to take an active role in providing a safe environment for their children (Stoiber and Kratochwill, 1998).

Numerous studies have looked at the risk factors associated with Sudden Infant Death Syndrome (SIDS). After an educational campaign discouraging the use of the prone sleeping position, Dwyer, Ponsonby, Bizzard, Newman, and Cochrane (1995) found a decline in SIDS. This and other studies show that health education on appropriate child-care practices can reduce illness and death.

Activities for objective:

1. Well baby visits.
2. Immunizations.
3. Management of sick child.
4. Medical access.
5. Age-appropriate safety.
6. Crib safety.
7. Sun protection.
8. SIDS risk factors.
9. Child neglect issues.
10. Poison ingestion management.
11. Basic first aid skills.

CONCLUSION

To understand children, their development, needs, and uniqueness is vital for parents. Each child is different in abilities and in the extraordinary way that he or she sees the world. Understanding children can result in less conflict between parent and child. Understanding is also an important part of helping children become secure and healthy

people. Children are not likely to become caring, loving people if they have not experienced understanding from people who are close to them (Smith, Cudaback, Goddard, and Myers-Walls).

References

Bullock, L., & McFarlane, J. (1989). Higher prevalence of low birthweight infants born to battered women. *American Journal of Nursing*, 89, 1153-1155.

Bullock, L., McFarlane, J., Bateman, L. H., & Miller, V. (1989). The prevalence and characteristics of battered women in a primary care setting. *Nurse Practitioner*, 14, 47-55.

Cicchetti, D., & Braumwald, K. G. (1984). An organizational approach to the study of emotional development in maltreated infants. *Infant Mental Health Journal*, 5 (3), 172-183.

Cokkinides, V. E. and Coker, A. L. (1998). Experiencing physical violence during pregnancy: prevalence and correlates. *Family & Community Health*, 19-37.

Dwyer, T., Ponsonby, A. L., Newman, N. M., & Cochrane, J. A. (1995). The contribution of changes in the prevalence of prone sleeping position to the decline in Sudden Infant death Syndrome in Tasmania. *Journal of American Medical Association*, 273 (10), 783-789.

Freed, G. L., Clark, S. J., Sorenson, J., Lohr, J. A., Cefalo, R., & Curtis, P. (1995). National assessment of physicians' breast feeding knowledge, attitudes, training, and experience. *Journal of American Medical Association*, 273 (6), 472-476.

Greenspan, S., & Lourie, R. (1981). Developmental structuralist approach to the classification of adaptive and pathological personality organization: application to infancy and early childhood. *American Journal of Psychiatry*, 138, 725-736.

O'Donohue, W., & Krasner, L. (1995). *Handbook of Psychological Skills Training: Clinical Techniques and Application* Library of Congress Cataloging-in-Publication Data.

Stoiber, K. C. & Kratochwill, T. R. (1989). *Handbook of Group Intervention for Children and Families*. Library of Congress Cataloging-in-publication Data.

Kaplan, P. S. (1988). *The Human Odyssey* West Publishing Co. St. Paul.

Olds, D. L., Henderson, C., Tatelbaum, R., & Chamberlin, R. Improving the delivery of prenatal care and outcomes of pregnancy: A randomized trial of nurse home visitation. *Pediatrics*, 1986a. 77. 16-28.

Powell, D.G. (1986). Parent education and support programs. *Young Children*, 47-53.

Schmitt, B. D. (1987). Seven deadly sins of childhood: Advising parents about difficult developmental phases. *Child Abuse and Neglect*, 11, 421-432.

Spinetta, J., & Rigler, D., 1972. The child-abusing parent: A Psychological review. *Psychological Bulletin*. 77, 296-304.

Smith, C. A., Cudaback, D., Goddard, H. W., & Myers-Walls, J.

Turley, M. A. (1985). A meta-analysis of informing mothers concerning the sensory and perceptual capabilities of their infants: The effects on maternal-infant interaction. *Maternal child Nursing Journal*, 14, 183-197.

Sample Activity Sheet Follows.

NURSING PRACTICE ACTIVITY SHEET: Objective No. 4

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives
To support mission readiness and build healthy resilient Air Force communities by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal to three years old.	<i>Increase knowledge of child growth and development</i>
Measurement (Outcome):	Individual Practice Objective
Reports child achieved appropriate developmental milestones	<i>Educate about age appropriate behavior</i>
Normal Ages and Stages	Teach healthy prenatal life style
Environment assessed as safe for age(s)	Educate on health and safety issues
Evidence mother is practicing healthy prenatal lifestyle	Practice Activities
Observed child to be WNL for Ht/Wt	<i>1 Teach Keys to Caregiving</i>
Parent reports well baby checks/immunizations	<i>2. Assist parent in evaluating child's developmental stages</i>
Parent can state S/S of illness and takes appropriate action	<i>3. Enable parent to recognize/report any deviation on child growth and development (and be able to seek out information/help)</i>
Positive HOME inventory	<i>4. Encourage and support breast feeding</i>
	<i>5. Educate on age appropriate nutrition</i>
	<i>6. Teach child proofing</i>
	<i>7. Discuss health lifestyle during pregnancy</i>
	<i>8. Provide I & R</i>

C. NPSP Role of the Family Advocacy Treatment Manager

1. Introduction

The multidisciplinary provision of services is an essential component of the NPSP. The professional social worker brings to the program an intensive clinical knowledge base as well as the necessary experience to compliment the multidisciplinary team. While the social worker does not function as a counselor or therapist in the traditional sense (e.g., long-term psychotherapy), a clinical framework provides guidelines for effective assessment, and provision of social work services. In addition to these family-focused and team contributions, the FATM will assist in the assessment of community needs and the provision of services to meet the identified needs.

2. Family

When the NPSP team determines a social work intervention would be appropriate, the Family Advocacy Treatment Manager will provide a thorough assessment, which addresses the family's needs, issues, concerns as well as clinical considerations. (See Social Work Assessment Instructions)

The intensity and frequency of the Family Advocacy Treatment Manager's interventions will be determined through a multidisciplinary team approach and take into consideration the family's needs, staffing resources, and current caseloads.

The FATM will utilize the term "social work interventions" to describe individualized services when working with families.

The FATM will utilize the clinical skills built upon the traditional social work roles of educator, advocate, broker and enabler. These roles are then guided by use of the empowerment strategies, which address problems, while maintaining a focus on individual, family and community strengths.

In collaboration with the family and in consultation with NPSP team a Family Service Plan (FSP) is developed, which may include referrals and information, case management services, psycho-educational teaching, and/or family specific social work interventions (listed in detail under interventions).

The FATM possesses knowledge of the psychological/developmental issues of the infant/child, the parents, as well as the family. Intervention techniques, which evidence an optimistic view of people's motivation towards growth and change, serve the FATM well. The recent wealth of knowledge of early brain development provides critical information in shaping services.

The FATM will utilize the NPSP Case Level Conceptualization and Practice sheets to establish practice objectives and activities to accomplish agreed family changes.

The practice objectives and/or other appropriate activities devised by the FATM together with the family members will be added to the Family Service Plan (FSP).

Some core values and theoretical underpinnings of social work are important considerations for use by the FATM in the NPSP, for instance, cultural sensitivity to include both the ethnic and the military family cultural issues. Another example is the ecological systems theoretical framework, which recognizes that the complex, interactive, mutually influencing factors of the person within the environment is an essential tool.

The FATM's expertise in the problem-solving model, used in conjunction with brief solution-focused therapy, and occasionally the crisis intervention approach, shapes the process of change.

When working with a family in the home (as opposed to an office visit) each FATM will use their social work knowledge and skills in deciding what interventions to use, as well as how to use them. For example, when a service plan identifies the family's desire to improve their parenting discipline strategies, a FATM may sit on the floor, playing a dump and pour game with a bucket of blocks with a toddler, while discussing the mother's specific concerns for her child's behaviors. The FATM is starting where the participant is---the business of day-to-day family life, modeling age appropriate and respectful adult/child interactions, while building a relationship with the parent and the child, and providing parent education. The FATM will provide experiences in various modalities of family therapy to provide guidelines for framing the family centered service delivery espoused by the program.

The primary goal of social work interactions will be empowerment of the parents, rather than focusing on the FATM's relationship with the child. When interacting with the family, the FATM will ensure that interventions do not undermine the parents' confidence in their parenting abilities. The FATM is not providing child play therapy, but some social work interventions may include interactions with infants and children, such as modeling respectful limit setting or modeling developmentally appropriate play. For example, rather than taking over and calming a fussy baby, the FATM could empathize with the mother on the challenge of learning the baby's cues, give a suggestion or two for techniques to use, followed up with positive reinforcement to the mother.

The following universal social work interventions may be helpful in achieving the goals and objectives of the New Parents Support Program:

Establishing Rapport and Trust	Role Play
Modeling	Re-framing
Positive Reinforcement	Problem solving
Communication Skills	Encouragement
Cultural Sensitivity	Parenting Skills
Referrals	Stress Management
Anger Control	Conflict Resolution
Relaxation	Teaching
Behavior Management	Role Clarification
Self Care	Assertiveness
Active Listening	Reflective Feelings
Community Linkages	Referrals

3. Team

The social worker will add to the NPSP team their knowledge and expertise in family systems, family dynamics, identifying and addressing psychosocial stressors, and facilitating the change process.

This expertise will contribute to the team in case staffings and provision of services.

The FATM will serve as a consultant/educator to the team, since all families will not require specific social work interventions, or in cases of staffing limitations where social work interventions are limited.

4. Community

The FATM is knowledgeable about comprehensive services and resources available to families in the military and surrounding civilian communities.

In collaboration with the NPSP team and the installation IDS, the FATM will evaluate the needs of the community and implement needed services to promote community resilience. This may include development of class curriculum as well as teaching or facilitating groups.

In the capacity of marketing NPSP, the FATM may provide briefings and assist in the planning and implementation of prevention events. The FATM will network with related agencies and other professionals including providing consultation services, as needed.

**New Parent Support Program
FATM Role
Core Program Objectives**

1. Decrease Family Potential for Maltreatment:

Measurable indicators exist which place families at risk for maltreatment. Screening tools and clinical assessments of these risk factors guide effective interventions to improve the safety and well-being of the family. Likewise, promotion of community education and support programs, and community-focused interventions result in increased community resiliency and the reduction of family maltreatment.

References

Altemeier, W. A. , O'Connor, S., Vietze, P.M., Sandler, H.M., & Sherrod, K.B. (1982). Antecedents of child abuse. *Journal of Pediatrics*, 100, 823-829.

Alvy, K.T. (1994). *Parent Training Today*. Studio City, CA: Center for the Improvement of Child Caring.

Amaro, H., Fried, L.E., Cabral, H., & Zuckerman, B. (1990). Violence during pregnancy and substance use. *American Journal of Public Health*, 80, 575-579.

Barth, R.P., Hacking, S., & Ash, J.R. (1988). Preventing child abuse: An experimental evaluation of the Child Parent Enrichment Project. *Journal of Primary Prevention*, 8 (4), 201-217.

Belsky, J., Rovine, M., & Taylor, D. (1984). The Pennsylvania infant and family development project, III: The origins of individual differences in infant-mother attachment. *Child Development*, 55, 718-728.

Campbell, J., Poland, M. Walder, J., & Ager, J. (1992). Correlates of battering during pregnancy. *Research in Nursing and Health*, 15 (3), 219-226.

Culp, R.E., Culp, A. M., Soulis, J., & Letts, D. (1989). Self-esteem and depression in abusive, neglecting, and non-maltreating mothers. *Infant Mental Health Journal*, 10, 243-251.

Dutton, D. G. (1994). The origin and structure of the abusive personality. *Journal of Personality Disorders*, 8(3), 181-191.

Frodi, A.M., & Lamb, M.E. (1980). Child abusers' responses to infant smiles and cries. *Child Development*, 51, 238-241.

Garbarino, J. (1982). *Children and Families in the Social Environment*. New York: Aldine.

Gelles, R.J. (1973). Child abuse as psychopathology: A sociological critique and reformulation. *American Journal of Orthopsychiatry*, 43(4), 611-621.

Gelles, R.J. & Straus, M.A. (1979). Determinants of violence in the family: Toward a theoretical integration. In W. R. Burr, R. Hill, F.I. Nye, & I.L. Reiss (Eds.), *Contemporary Theories About the Family* (Vol. 1). New York: Free Press.

Goldson, E. (1991). The affective and cognitive sequelae of child maltreatment. *Pediatric Clinics of North America*, 38 (6), 1481-1496.

Gondolf, E. W. (1988). Who are those guys? Toward a behavioral typology of batterers. *Violence and Victims*, 3(3), 187-203.

Graziano, A.M., & Diament, D.M. (1992). Parent behavioral training: An examination of the paradigm. *Behavior Modification*, 16, 3-38.

Green, A. (1998). Factors Contributing to the generational transmission of child maltreatment. *Journal of the American Academy of Child and Adolescent Psychiatry*, 37:12, 1334-1336.

Guterman, N.B. (1997). Early prevention of physical child abuse and neglect Existing evidence and future directions. *Child Maltreatment*, 2(1), 12-34.

Hamberger, L.K., & Hastings, J.E. (1986). Characteristics of spouse abusers: Predictors of treatment acceptance. *Journal of Interpersonal Violence*, 1(3), 363-373.

Hamby, S. L. (1998). Partner violence: Prevention and intervention. In J.L. Jasinski & L.M. Williams (Eds.), *Partner Violence: A Comprehensive Review of 20 Years of Research* (pp. 210-258). Thousand Oaks, CA: Sage Publications.

Hansen, D. J., Pallotta, G.M., Tishelman, A.C., Conaway, L.P., & MacMillan, V.M. (1989). Parental problem-solving skills and child behavior problems: A comparison of physically abusive, neglectful, clinic, and community families. *Journal of Family Violence*, 4, 353-368.

Holtzworth-Munroe, A. (1997). Violent versus nonviolent husbands: Differences in attachment patterns, dependency, and jealousy. *Journal of Family Psychology*, 11, 314-331.

Holtzworth-Munroe, A., Markman, H., O'Leary, K.D., Neidig, P., Leber, D., Heyman, R.E., Hulbert, D., & Smutzler, N. (1995). The need for marital violence prevention efforts: A behavioral cognitive secondary prevention program for engaged and newly married couples. *Applied & Preventive Psychology*, 4, 77-88.

Kalmuss, D. (1984). The intergenerational transmission of marital aggression. *Journal of Marriage and the Family*, 46, 11-19.

Kaufman, J., & Zigler, E. (1993). The intergenerational transmission of child abuse. In D. Cicchetti & V. Carlson (Eds.), *The Handbook of Child Maltreatment*. Cambridge: Cambridge University Press.

Kaufman Kantor, G., & Jasinski, J.L. (1998). Dynamics and risk factors in partner violence. In J.L. Jasinski & L.M. Williams (Eds.), *Partner Violence* (pp.1-43). Thousand Oaks, CA: SAGE Publications.

Kitzman, H., Olds, D.L., Henderson, C.R., Hanks, C., Cole, R., Tatelbaum, R., McConnochie, K.M., Sidora, K., Luckey, D., Shaver, D., Engelhardt, K., James, D., & Barnard, K. (1997). Effect of prenatal infancy home visitation by nurses on pregnancy outcomes, childhood injuries, and repeated childbearing: A randomized controlled trial. *JAMA*, 278, (8), 644-652.

Levy, B. (1984). *Skills for Violence-Free Relationships*. Santa Monica, CA: Southern California Coalition on Battered Women.

Lutzker, J. R., Wesch, D., & Rice, J.M. (1984). A review of Project 12 Ways: An ecobehavioral approach to the treatment and prevention of child abuse and neglect. *Advances in Behavioral Research and Therapy*, 6, 63-73.

Markman, H.J., & Floyd, F. (1980). Possibilities for the prevention of marital discord: A behavioral perspective. *American Journal of Family Therapy*, 8, 29-48.

Milner, J.S., & Dopke, C.A. (1997a). Child physical abuse: Review of offender characteristics. In R. Peters (Ed.), *Child Abuse: New Directions in Prevention and Treatment Across the Life Span*, 25-52. Thousand Oaks, CA: Sage.

Milner, J.S., & Wimberly, R.C. (1979). An inventory for the identification of child abusers. *Journal of Clinical Psychology*, 35, 95-100.

Mollerstrom, W., Patchner, M. & Milner, J. (1995). Child maltreatment: The United States Air Force's response. *Child Abuse & Neglect*, 19:3, 325-334.

National Center on Child Abuse and Neglect. (1983a). *Collaborative Research of Community and Minority Group Action to Prevent Child Abuse and Neglect: Volume I: Perinatal Interventions. Part II. Perinatal Positive Parenting*. Washington, DC: US Department of Health and Human Services.

National Center on Child Abuse and Neglect. (1983b). *Collaborative Research of Community and Group Action to Prevent Child Abuse and Neglect: Pride in Parenthood*. Washington, DC: US Department of Health and Human Services.

Olds, D., Hill, P., & Rumsey, E. (1998). Prenatal and early childhood nurse home visitation. *UJJDP Juvenile Justice Bulletin*, 1-7.

Olds, D.L., & Henderson, C.R., Jr. (1989). The prevention of maltreatment. In D. Cicchetti & V. Carlson (Eds.), *Child Maltreatment: Theory and Research on the Causes and Consequences of Child Abuse and Neglect*, 722-763. Cambridge: Cambridge University Press.

Peterson, J., & Hawley, D. R. (1998). Effects of stressors on parenting attitudes and family functioning in a primary prevention program. *Family Relations*, 47, 221-227.

Polansky, N.A., Chalmers, M.A., Williams, D.P., & Bittenweiser, E. W. (1981). *Damaged Parents: An Anatomy of Child Neglect*. Chicago: University of Chicago Press.

Shorkey, C.T., & Armendariz, J. (1985). Personal worth, self-esteem, anomia, hostility, and irrational thinking in abusing mothers: A multivariate approach. *Journal of Clinical Psychology*, 41, 414-421.

Susman, E.J., Trickett, P.K., Lannotti, R.J., Hollenbeck, B.E., & Zahn-Waxler, C. (1985). Child-rearing patterns in depressed, abusive, and normal mothers. *American Journal of Orthopsychiatry*, 55, 237-251.

Wesch, D., & Lutzker, J. (1991). A comprehensive 5-year evaluation of Project 12 Ways: An Ecobehavioral Program for Treating and Preventing Child Abuse and Neglect. *Journal of Family Violence*, 6, 17-35.

FATM Activity Sheet
Objective #1

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives (Evidence Based):
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal up to three years old.	Decrease Family Potential for Maltreatment ⇒ Increase parental well-being, including self-esteem & self-efficacy ⇒ Enhance couple cohesion and problem solving
Measurement (Outcome):	Individual Practice Objective(Evidence Based) :
Social Work Assessment	<ul style="list-style-type: none"> • Increase knowledge of strengths and assets as a parent
Parent/s will keep scheduled appointments	<ul style="list-style-type: none"> • Enhance couple cohesion & problem solving abilities
Administer additional assessment tools (CESD, MAST, AIC, Q/F) as appropriate.	<ul style="list-style-type: none"> • Teach parents to identify and respond to the needs of their spouse
	Activities(Evidence Based): Attachments for Research and Evidence Based
Family reports improved family functioning	1. <i>Identify present family interactions. Discuss strengths and weaknesses of current functioning.</i>
Couple reports decreased conflict Administer CTS pre- & post-intervention	2. <i>Assess abuse dynamics in the family. Evaluate potential for maltreatment.</i>
Re-administer CESD, MAST, AIC, Q/F	3. <i>Help family improve awareness of warning signs and patterns of negative behavior that occur as stress increases in the family. Assist the family with developing ways to interrupt this progression. Teach de-escalation techniques.</i>
FATM reports	4. <i>Provide screening and assessment of suicidal/homicidal risk and possible mental illness. Make appropriate referrals for treatment.</i>
Zero reports of maltreatment. Participant demonstrates increased positive communication skills.	5. <i>Teach appropriate response patterns to include a proactive safety plan.</i>

	6. <i>Provide screening and assessment of possible substance abuse problems. Make appropriate referrals for treatment</i>
Improved participant self-report of feeling heard and understood by partner.	7. <i>Explore family-of-origin issues regarding domestic violence and the current impact on the family.</i>
	8. <i>Probe and address impact of risk factors on family functioning.</i>
	9. <i>Teach parents to identify and respond to needs of their spouse. Consider referral to PREP (Marriage Enrichment) course or utilizing materials with the couple.</i>
	10. <i>Provide solution-focused counseling for Family-specific difficulties.</i>
	11. <i>Teach new ways to respond to spouse's or child's behavior.</i>

**New Parent Support Program
FATM Role
Core Program Objectives**

2. Enhance Family Member Role Adaptation:

The critical element of facilitating a parent's role adaptation can reduce the negative impacts of the stressors inherent to any changes within the family. Role changes occur due to pregnancy, birth, blending of families, frequent military moves or deployments, occupational changes/stress, and illness. Education regarding role changes is necessary, but may need to be further supported by exploring the parent's internal working model of relationships, parenting and spousal roles. Parents with healthy self-esteem and self-efficacy are more adaptive and have decreased incidence of maltreatment. The social worker normalizes the challenges associated with role change by providing a climate of acceptance. This allows the individual to explore old patterns and generate new options.

References

- American Psychological Association. (1998). *What makes kids care?* Washington: American Psychological Association Press.
- Berg, Insoo K. (1992). *Family based services: A solution-focused approach*. Milwaukee: Brief Family Therapy Center Press.
- Burke, R., & Herron, R. (1996). *Common sense parenting*. Boy's Town: Boy's Town Press.
- Carter, E. (1980). *The family life cycle: A framework for family therapy*. New York: Gardner Press, 1980
- Darragh, J. (1994). Promoting nurturant fathering. In Todd, C. (Ed.), *Child care center connections*, 3 (3), Urbana-Champaign, IL: University of Illinois Cooperative Extension Service, 4-5.
- DeShazer, S. (1985). *Keys to solution in brief therapy*. New York: W. W. Norton, 1985.
- Diapers & Delirium (Video). Newton, MA: Lifecycle Productions. 1987.
- Driscoll, J., & Walker, M. (1996). *Taking Care of Your New Baby (Postpartum Depression)*. Garden City Park: Avery Publishing Group, 167-171.

Postpartum Onset Specifier. (1994). In Diagnostic & Statistical Manual- IV. Washington: APA, 386-387.

Dunst, C., Trivette, C. & Thompson, R. (1988). *Enabling and Empowering Families*. Cambridge: Brookline Books.

Einstein, E. & Albert, L. (1986). *Strengthening your stepfamily*. Circle Pines: American Guidance Service.

Gatti, F. & Colman, C. (1976). Community network therapy: An approach to aiding families with troubled children. *American Journal of Orthopsychiatry*, 46, 608-617.

Goddard, H. (1998). *Building Family Strengths*. Department of Family and Child Development, Auburn University.

Hales, D. (1994). Working Mother Magazine (Loving Discipline). March , 49-52.

Haley, J. (1976). *Problem-Solving Therapy*. San Francisco: Jossey-Bass.

Johnson, J. & Johnson, M. (1983). *Miscarriage*. Omaha: Centering Corporation, 1983.

Kaslow, F. & Ridenour, R. (Eds.). (1984). *The military family: Dynamics and treatment*. New York: Guilford Press.

Madanes, C. (1981). *Strategic Family Therapy*. San Francisco: Jossey-Bass, 1981.

McCubbin, H. & McCubbin, M. (1998). *Families under stress*. Madison: University of Wisconsin System, 1998.

McCubbin, H. & McCubbin, M. (1986). *Resilient families, competencies, supports and coping over the life cycle*. In L. Sawyers (Ed.), Faith and Families. Philadelphia: Geneva Press.

McGoldrick, M., & Gerson, R.. (1985). *Genograms in family assessment*. New York: Norton Press.

New Fathers, New Lives (Video). Boulder: Injoy Productions. (303-447-2082)

Papero, Daniel (1990). *Bowen family systems theory*. Boston, MA; Allyn & Bacon.

- Postpartum: A Bittersweet Experience (Video). Boulder: Injoy Productions.
- Reed, B. (1982). *Merging Families*. New York: Concordia Publishing Company, 1992.
- Satir, V. *Peoplemaking*. Palo Alto: Science and Behavior Books, 1972.
- Sears, W. & Sears, M. (1993). Postpartum Depression. In *The Baby Book*. Boston: Little Brown and Company, 65-69.
- Smith, C. (1996). *Father's care* (Extension Publication L-650). Manhattan, KS: Kansas State University Cooperative Extension Service.
- Sviridoff, M. & Ryan, W. (1996). *Prospects and strategies for community-centered family service*. Milwaukee: Family Service America.
- Visher, E. & Visher, J. (1988). *Old loyalties, new ties: Therapeutic strategies with stepfamilies*. New York: Brunner/Mazel, Inc.
- Wheat, R. (1995). *Miscarriage*. Omaha: Centering Corporation.

FATM Practice Activity Sheet
Objective #2

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives (Evidence Based):
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal up to three years old.	Enhance Family Member Role Adaptation ⇒ Increase & enhance father/mother involvement in child care ⇒ Enhance parental well-being including self-esteem and self-efficacy
Measurement (Outcome):	Individual Practice Objective(Evidence Based) :
Social Work Assessment	<ul style="list-style-type: none"> Educate parent(s) on how to promote and empower healthy role changes occurring within the family
Participant Report	<ul style="list-style-type: none"> Promote age appropriate expectations
Observe Family Interaction	<ul style="list-style-type: none"> Identify the parent's internal working model of relationships
	<ul style="list-style-type: none"> Increase parent's awareness of personal needs Enhance family member's ability to address personal needs
	Activities (Evidence Based):
Participant demonstrates positive use of communication skills during interaction with FATM and others.	1. <i>Help family negotiate and establish clear roles and boundaries particularly for blended families, severe sibling rivalry, and "parentified" child.</i>
Participant able to identify positive interactions that have occurred since last visit	2. <i>Assist family with developing and implementing child-specific discipline plans.</i>
FATM documents positive reinforcement for participant's new skills learned	3. <i>Explore and encourage family members to participate in self-nurturing activities.</i>
Participant reports participation in nurturing activity since last visit	4. <i>Help parents alter maladaptive internal working models of relationships.</i>
	1. <i>Assist family with identifying communication difficulties. Teach communication skills. Encourage productive dialogue about individual needs among family members.</i>
	2. <i>Identify and reduce maternal depressive symptoms. Make referrals as needed.</i>
	3. <i>Address grief issues for families experiencing miscarriage/loss.</i>

**New Parent Support Program
FATM Role
Core Program Objectives**

3. Increase Problem Solving Skills for Family:

The proficient use of the problem solving process increases the family's ability to explore options and implement positive strategies, which decreases maladaptive, impulsive responses. When parents learn to solve problems they become more assertive, flexible, confident and effective.

References

- Burns, D. (1989). *The feeling good handbook*. New York: Plume/Penguin.
- Dinkmeyer, D. & Carlson, J. (1989). *Time for a better marriage*. Circle Pines, MN: American Guidance Service.
- Dinkmeyer, D. & McKay, G. (1989). *PREP for effective family living*. Circle Pines, MN: American Guidance Service.
- Dinkmeyer, D. & McKay, G. (1989). *The parent's handbook*. Circle Pines, MN: American Guidance Service.
- Einstein, E. & Albert, L. (1986). *Strengthening your stepfamily*. Circle Pines, MN: American Guidance Service.
- Gottman, J. & Notarius, C. (1976). *A couple's guide to communication*. Champaign, IL: Research Press.
- Hart, L. (1993). *The winning family: Increasing self-esteem in your children and yourself*. Berkeley CA: Celestial Arts.
- Markman, H. & Stanley, S. & Blumberg, S. (1994). *Fighting for your marriage*. San Francisco: Jossey-Bass.
- Philpot, C.L. (1997). *Bridging separate gender worlds: Why men and women clash and how therapists can bring them together*. Washington, D.C.: American Psychological Association.
- Pinsker, L. & Longe, M. (1990). *Kopy kit: Managing work & family*. Emeryville, CA: Parlay International.
- Sattler, J.M. (1998). *Clinical and forensic interviewing of children and families*. San Diego: Jerome M. Sattler.
- Shehan, C.L., & Kammeyer, K. (1997). *Marriages and families: Reflections of a gendered society*. Boston: Allyn and Bacon.

Sonkin, D.J. & Durphy, M. (1989). *Learning to live without violence: A handbook for men*. Volcano, CA: Volcano Press.

Tohn, S.L. (1995). *Crossing the bridge: Integrating solution-focused therapy into clinical practice*. Natick, MA: Solutions Press.

FATM Practice Activity Sheet
Objective #3

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives (Evidence Based):
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal up to three years old.	Increase Problem Solving Skills for Family ⇒ Enhance stress management and coping skills ⇒ Promote appropriate use of military & community resources
Measurement (Outcome):	Individual Practice Objective(Evidence Based) :
Participant Report	<ul style="list-style-type: none"> • Increase life skills
	<ul style="list-style-type: none"> • Increase ability to generate options under stress
	Activities(Evidence Based): Attachments for Research and Evidence Based
	1. <i>Teach problem solving skills. Assess learning and retention of problem solving information; assist with putting the problem solving process into action within the family.</i>
Parent reports utilization of community resources	2. <i>Connect family to community resources.</i>
Participant reports an improved sense of well being & family experiencing a decrease in crisis	3. <i>Assist family in identifying maladaptive patterns of behavior and developing healthy ones.</i>
	4. <i>Provide assistance with family-specific personalized problem solving.</i>
FATM observes positive behavior changes and appearance	5. <i>Teach effective stress management strategies and techniques.</i>
	6. <i>Enhance parents self-esteem, self-efficacy, and assertiveness skills.</i>
	7. <i>Encourage interaction between families to increase social support and decrease isolation.</i>

**New Parent Support Program
FATM Role
Core Program Objectives**

4. Increase Knowledge of Child Growth and Development:

Research validates that parents who are knowledgeable of developmentally appropriate expectations of their infants and children are more tolerant of challenging behaviors, and more confident in their abilities to care for their children. This decreases the risk for maltreatment and increases positive interactions.

The potential for positive bonding and attachment is enhanced when parents know how to interpret infant cues and respond appropriately. Secure attachment beginning in infancy has positive life long implications.

References

Acredolo, L. & Goodwyn, S. (1996). *Baby signs: How to talk with your baby before your baby can talk*. Chicago, IL: Contemporary Books.

Bowlby, J. (1988). *A secure base: Parent-child attachment and healthy human development*. New York: Basic Books.

Clark, R., Paulson, A. & Seidl, M. (1998). Relationship-focused group intervention for at-risk families with infants and young children. Chapter in Book: *Handbook of group interventions for children and families*. Boston, MA: Allyn & Bacon.

Fraiberg, S. (Eds.). (1994). *Assessment and therapy of disturbances in infancy*. Northvale, NJ: J. Aronson Publishers.

Fraiberg, S. (1996). *The magic years: Understanding and handling the problems of early childhood*. New York: Simon & Schuster.

Fraiberg, S. (1987). *Ghosts in the nursery: A psychoanalytic approach to the problems of impaired infant-mother relationships*. New York: Simon & Schuster.

Greenspan, S. & Lieberman, A. (1980). Infants, mothers and their interaction: A quantitative clinical approach to developmental assessment. In Greenspan and Pollock, (Eds.), *The course of life: Psychoanalytic contributions towards understanding personality development. Vol. I: Infancy and early childhood*. (271-312). Maryland: U.S. Department of Health and Human Services.

Gruber, H. & Voneche, J. (Eds.). (1977). *The essential Piaget*. New York: Basic Books.

Humbree-Kigin, T. & McNeil, C. (1995). *Parent/Child interaction therapy: A step-by-step guide for clinicians*. New York: Plenum Press.

- Jernberg, A. (1979). *Theraplay*. San Francisco, CA: Jossey-Bass Publishers.
- Mahler, M. (1975). *The psychological birth of the human infant*. New York: Basic Books.
- Martin, Elaine (1988). *Baby Games: The joyful ride to child's play from birth to three years*. Don Mills, Ontario: Stoddart Publishing.
- McCubin, H. & Dahl, B. (1985). *Marriage and family: Individuals and life cycles*. New York: MacMillan Publishing Co.
- McGoldrick, M. & Carter, B. (Eds.). (1988). *The changing family life cycle: A framework for family therapy*. New York: Gardner Press
- Morton, N. & Brown, K. (1998). Theory and observation of attachment and its relation to maltreatment: Review. *Child Abuse & Neglect*, 22, 1093-1104.
- Schaefer, C. & O'Conner, K. (Eds.). (1994). *Handbook of play therapy*. New York: Wiley Press.
- Schneider McClure, V. (1982). *Infant massage*. New York: Bantam Books.
- Stattler, J. (1998). *Clinical and forensic interviewing of children and families*. San Diego, CA: Jerome A. Stattler.

FATM Practice Activity Sheet
Objective #4

NPS Program Objectives and Measurements	NPS Practice Activities
Key Program Goals:	Core Program Objectives (Evidence Based):
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children prenatal up to three years old.	Increase Knowledge of Child Growth and Development ⇒ Enhance children's physical, emotional, and development well being
Measurement (Outcome):	Individual Practice Objective(Evidence Based) :
Administer Ages & Stages	<ul style="list-style-type: none"> • Modeling • Positive reinforcement of parental behavior • Teaching age-appropriate milestones in physical development • Teaching age-appropriate psychosocial milestones and expectations
HOME inventory	Activities (Evidence Based):
Reports of healthy prenatal lifestyle and environment	
Observe parent/child interaction	4. <i>Assess learning and retention of growth and development information and assist in integrating information into everyday life.</i>
Parents report having spent increased play time with child and having a positive experience	5. <i>Assess and address bonding difficulties. Screen for possible reactive/attachment problems.</i>
FATM observes parents' appropriate stimulation of child	6. <i>Role model and educate parent about age-appropriate play with child. Encourage parental engagement in their child's play.</i>
FATM documents activity & discussion with parent about parent/child's activity	7. <i>Explore and resolve current impact of family of origin issues, which cause barriers to parent facilitating their child's development.</i>

Documentation of Interventions:

Documentation of our services attests to the overall effectiveness of the provider/team interactions and outcomes with the family. Standardization of documentation ensures that all recipients of home visits across the Air Force are provided the same standard of care, based on current research. Documentation should be clear, concise and provide a chronological record of interventions and outcomes, which all team members can use and understand. Each entry should be directly linked to the goal listed on the Family Service Plan (FSP). Therefore, it is appropriate to number each goal and simply refer to the goal by number when you mention it in your participant contact note. FSPs should be updated as goals are accomplished.

D. NPSP Role of the Family Advocacy Outreach Manager

1. Introduction:

- a. The primary role of the Outreach Manager in the AF Family Advocacy Program is to advocate for nonviolent communities in order to reduce the number and severity of family violence incidents. This is accomplished by increasing community awareness, providing quality of life education and skill building, and developing and coordinating community organization initiatives and partnerships.
- b. The Outreach Manager's role in the NPSP is consistent with their role in the FAP. For the NPSP, it is defined as it relates to FAMILY, TEAM and COMMUNITY.

2. Family:

- a. Identify, develop, implement, facilitate and/or participate in teaching:
 - (1) Early childhood development education.
 - (2) Age-appropriate behavior in children.
 - (3) Parent/child relationship and discipline strategies.
 - (4) Couple and family communication.
 - (5) Dynamics, recognition, prevention and reporting of child and spouse abuse.
 - (6) Availability and appropriate use of community resources.
 - (7) Skills in advocacy, networking and community building.
 - (8) Families to build connections between themselves and agencies.
 - (9) Research-based family violence prevention to NPS families.
 - (10) Family life skills.
 - (11) Skills in collaboration and community action.
 - (12) Issues that facilitate father/child bonding and relationship building.
 - (13) Relationship building activities and groups, i.e., Moms, Pops and Tots.
- b. During classes, briefings, activities, promote the NPSP to potential participants.

3. Team:

- a. Take leadership role in developing the Marketing Plan for the NPSP.
- b. Facilitate enhancement of the FAP staff marketing skills.
 - (1) Facilitate the staff's development and implementation of key strategies for marketing the NPSP.
 - (2) Provide the FAP team with resource linking assistance; seeking out community programs that will be beneficial to the NPSP families.
- c. Provide in-service training concerning:
 - (1) Customer service and customer care.
 - (2) The recognition and reporting protocol for family maltreatment
- d. Assist with the coordination of NPSP activities. An example is a monthly "Gathering" for new NPSP and prospective high needs participants. Includes games and social activities that focus on issues important to new parents. Purposes are to introduce to the participants who will be receiving home visits to the NPSP team, to facilitate connections among participants, and to provide fun learning opportunities
- e. Facilitate staff awareness about family maltreatment prevention.
- f. As a member of the NPSP Case Staffing Team, provide, input on trend analyses of needs and help identify and develop programs that can address problem areas.

4. Community:

- a. Facilitate promotion of the NPSP.
 - (1) Promote visibility of NPSP's services and activities.
 - (2) Publicize information and service resources.
 - (3) Facilitate networking and connection building through media resources.
 - (4) Brief and participate in parent/teacher organization and civic meetings.
 - (5) Speak at local functions.
 - (6) Participate on business and corporate boards that support community building.
 - (7) Promote FAP services at community functions that promote support of families.
- b. Family Advocacy Program representative on Integrated Delivery System (IDS).
 - (1) Educate the IDS about the NPSP.
 - (2) Work with the IDS to identify current gaps in service as it applies to the NPSP focus population.
- c. Participate with the FAP team in developing community partnerships that

support the needs of young families:

- (1) Assist agency staffs to develop skills in child maltreatment prevention.
- (2) Assist to develop collaboration, education and coordinated response strategies with appropriate helping agencies.
- (3) Promote awareness of AF and local community leaders on needed policy, and programs for new birth families and pregnant mothers.
- (4) Promote community leadership support for NPSP client issues and needs.
- (5) Facilitate working alliances with key community resource leaders and agencies.
- (6) Promote connections between NPSP families and community initiatives, programs and activities.
- (7) Develop collaborative relationships with domestic violence and child abuse prevention coalitions.

- d. Develop and implement family violence prevention education and strategies.
- e. Brief and encourage new birth father involvement in NPSP.
- f. Highlight issues associated with pregnant teens.
- g. Facilitate community resilience through participant/family/community empowerment.
- h. Facilitate the development of learning, action, and support groups.
 - (1) Take a key role in the development of needed programs to address the needs of the focus population of young families.
 - (2) Ensure the needs of these families are identified when participating in developing the annual needs assessment.
- i. Facilitate development and support of new parent mentor programs

FAOM Practice Activity Sheet

Objective #1

NPSP Objectives and Measurements		NPSP Practice Activities	
Objective:		Core Practice Objectives:	
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children aged birth to three years.		Maximize knowledge, skills and ability and to build community resilience and facilitate reduction in family maltreatment	
Measurement :		NPSP Activities:	
		➤ Collaboration Education and Skill Development Training Advocacy Community Intervention and Service Linking Marketing	
		Individual Practice Objectives:	
		<ul style="list-style-type: none"> • Build connections between families and agencies • Develop partnerships for programs and services • Strengthen resource support for families • Facilitate seamless services to community 	
		Activities:	
Increase in community awareness (Survey)		1. <i>Network with people in agencies in communities.</i>	
Increase in service utilization (of IDS and other community services)		2. <i>Participant in program planning and implementation through the IDS.</i>	
Monitor trends in referrals		3. <i>Work jointly with community agencies on prevention activities.</i>	
Enhance identification of gaps in services		4. <i>Design, plan and participate in community partnership initiatives.</i>	
Reduce duplication in services			

FAOM Practice Activity Sheet

Objective #2

<i>NPSP Objectives and Measurements</i>	<i>NPSP Practice Activities</i>
Objective:	Core Practice Objectives:
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children aged birth to three years.	Maximize knowledge, skills and ability and to build community resilience and facilitate reduction in family maltreatment
Measurement :	NPSP Activities:
Pre/Post Test	Collaboration ➤ Education and skill development Training Advocacy Community Intervention and Service Linking Marketing
	Individual Practice Objectives:
	<ul style="list-style-type: none"> • Develop and implement best practice in family violence prevention education and strategies
	<ul style="list-style-type: none"> • Identify and share research-based literature with families and community
	<ul style="list-style-type: none"> • Foster attitude and behavioral change that promotes healthy lifestyles and reduce potential for family violence
	<ul style="list-style-type: none"> • Provide knowledge, awareness and skills that promote quality life management
	Activities:
Reduction in PSI scores for participants receiving ongoing home visits.	1. <i>Teach research-based family violence prevention to NPSP families and to the community at large.</i>
Positive feedback on customer satisfaction surveys	2. <i>Provide family life education materials to NPSP families and community.</i>
Increase in knowledge about appropriate parenting practices Increase in scores on an inventory measuring life skills (pretest-posttest)	3. <i>Identify, develop, implement, facilitate and/or teach:</i> <ul style="list-style-type: none"> • <i>early childhood development education.</i> • <i>age appropriate behavior in children.</i> • <i>parent/child relationship and discipline strategies.</i> • <i>couple and family communication.</i> • <i>dynamics, recognition, prevention and reporting of child and spouse abuse.</i> • <i>availability and appropriate use of community resources.</i> • <i>skills in advocacy, networking and community building.</i> • <i>Awareness and education of commanders and key leadership on the AF family and issues associated with the Family Advocacy Program.</i>

FAOM Practice Activity Sheet

Objective #3

<i>NPSP Objectives and Measurements</i>	<i>NPSP Practice Activities</i>
Objective:	Core Practice Objectives:
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children aged birth to three years.	Maximize knowledge, skills and ability and to build community resilience and facilitate reduction in family maltreatment
Measurement :	NPSP Activities:
	Collaboration Education and skill development ➤ Training Advocacy Community Intervention and Service Linking Marketing
	Individual Practice Objectives:
	<ul style="list-style-type: none"> • Provide information, education and awareness to staff personnel of base agencies on the Family Advocacy Program • Facilitate staff awareness in family maltreatment prevention • Assist agency staffs to develop skills in child maltreatment prevention • Develop collaboration, education and coordinated response strategies with appropriate helping agencies
	Activities:
Community Awareness Survey	1. <i>Brief agencies and Units on Family Advocacy Program (emphasis on NPSP).</i>
Increase in collaborative prevention efforts between FAP and other agencies	2. <i>Educate and train agency staff and units on dynamics and prevention strategies of child and spouse abuse.</i>
Increase in utilization of NPSP and community resources	3. <i>Train agency staff on techniques for appropriate child interaction and prevention strategies in the workplace.</i>
Pre/Post Test (Measuring knowledge, attitude, skills, behavior)	4. <i>Develop collaborative training in child and spouse abuse and response to each.</i>
Decrease in severity of incidence of family maltreatment	5. <i>Train staffs in recognition and reporting and in policy and procedure about child and spouse abuse.</i>

FAOM Practice Activity Sheet

Objective #4

<i>NPSP Objectives and Measurements</i>	<i>NPSP Practice Activities</i>
Objective:	Core Practice Objectives:
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children aged birth to three years.	Maximize knowledge, skills and ability and to build community resilience and facilitate reduction in family maltreatment
Measurement :	NPSP Activities:
	Collaboration Education and skill development Training ➤ Advocacy Community Intervention and Service Linking Marketing
	Individual Practice Objectives:
	<ul style="list-style-type: none"> • Promote community leadership support for NPSP participant issues and needs • Promote awareness of AF and local community leaders on needed policy and programs for new birth families and pregnant moms • Advocate for new birth fathers • Highlight issues associated with pregnant teens • Assist NPSP families and community in developing skills for community action strategies
	Activities:
Increase in Leadership support	1. Brief commander, civilian leaders and other key personnel on NPSP and related issues.
Increase in Information and Referral contacts with community members	2. Teach client and community, skills in collaboration and community action.
Enhance / establish needed resources for new parents and children aged birth to three years.	3. Develop support, learning and action groups.
Increase in awareness on survey measures	4. Educate community on single parent and new birth family issues.
	5. Develop collaborative relationships with domestic violence and child abuse prevention coalitions.
Policy development that supports new parents and children aged birth to three years	6. Promote issues that facilitate father/child bonding and relationship building.
	7. Participate on business and corporate boards that support community building.
	8. Brief and participate in parent/teacher organization and civic meetings.
	9. Develop and/or support mentor programs.
	10. Speak at local and other functions.

FAOM Practice Activity Sheet
Objective #5

<i>NPSP Objectives and Measurements</i>	<i>NPSP Practice Activities</i>
Objective:	Core Practice Objectives:
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children birth to three years.	Maximize knowledge, skills and ability and to build community resilience and facilitate reduction in family maltreatment.
Measurement :	NPSP Activities:
	Collaboration Education and skill development Training Advocacy ➤ Community Intervention and Service Linking Marketing
	Individual Practice Objectives:
	<ul style="list-style-type: none"> • Develop network and resource links for NPSP families • Facilitate working alliances with key community resource leaders and agencies • Promote connections between NPSP families and community initiatives, programs and activities • Facilitate early family intervention and support
	Activities:
Increase in participation in community initiatives, as noted by review of the Outreach Prevention Log (OPL)	1. <i>Attend community functions that promote family support.</i>
	2. <i>Facilitate visibility of FAP/NPSP at civic meetings.</i>
Increase in attendance at program interventions	3. <i>Participate in programs at schools, social service agencies and child development.</i>
Pre/Post Test (Increase in knowledge, skills, attitude, behavior)	4. <i>Engage families in relationship building activities and groups..ie Moms, Pops and Tots; A Time for Us, etc.</i>
Increase in utilization of community services/Info and Referrals	5. <i>Develop and implement Family and Community Information and Activity Fairs.</i>
Increase in community resiliency initiatives	6. <i>Develop and conduct community action workshops.</i>
	7. <i>Speak at local and other functions.</i>
	8. <i>Emphasize through community initiatives, the importance of early intervention with families with children 0-3.</i>

FAOM Practice Activity Sheet

Objective #6

<i>NPSP Objectives and Measurements</i>	<i>NPSP Practice Activities</i>
Objective:	Core Practice Objectives:
To support mission readiness by reducing family maltreatment and strengthening interpersonal functioning in families with children birth to three years.	Maximize knowledge, skills and ability and to build community resilience and facilitate reduction in family maltreatment.
Measurement :	NPSP Activities:
	Collaboration Education and skill development Training Advocacy Community Intervention and Service Linking ➤ Marketing
	Individual Practice Objectives:
	<ul style="list-style-type: none"> • Develop and conduct awareness campaign on NPSP • Facilitate and promote the principles of the NPSP and of the FAP • Promote visibility of NPSP, services and activities • Foster interest in early intervention and support of families with children 0-3 • Publicize information and service resources • Facilitate networking and connection building through media resources • Facilitate enhancement of the FAP staff marketing skills
	Activities:
	1. <i>Briefing and public speaking.</i>
Increase in participation and awareness of workshop and conferences focusing on young children	2. <i>Develop and disseminate publicity materials (flyers brochures, newsletters, business cards).</i>
Increase in service utilization	3. <i>Provide follow-up information and telephone contact to clients.</i>
Increase in knowledge and awareness of risk factors related to family violence	4. <i>Provide in-service training on customer service and customer care.</i>
	5. <i>Provide FAP consultation to commanders, base agencies and other key personnel.</i>
	6. <i>Provide internal marketing activities and training to foster FAP staff marketing skills.</i>
Increase in participation in annual FAP “Open House”	7. <i>Training on marketing to parents, informal leaders and community customers.</i>
	8. <i>Develop and Implement key strategies for marketing NPSP.</i>
Increase in participation at monthly “gatherings” for new NPSP participants	9. <i>Participate in coordinating a “Gathering” to facilitate participant/FAP staff relationship.</i>
	10. <i>Provide annual “in-service” on marketing for NPSP.</i>

E. NPSP Role of the Prevention Family Advocacy Program Assistant (FAPA) And Mental Health Technician

1. Introduction:

The FAPA and Mental Health Technician (Tech) provide administrative support for maltreatment and prevention FAP services. As members of the FAP NPSP multidisciplinary prevention team, support services are associated with both the home visitation and community intervention components of the NPSP. Supervised by the FAO and in cooperation with other NPSP team members, the FAPA and Tech may participate and assist in NPSP prevention briefings, training of personnel, home visits and other activities based upon their related experience, knowledge, skill and available time constraints.

2. Family:

The FAPA and Tech prevention responsibilities at the family level include:

- a. Assisting in administration of the Family Needs Screener (FNS) and some additional assessment tools.
- b. Scoring FNS core and additional assessment instruments.
- c. Entering NPSP data into database including demographics, scores, interventions, and outcomes.
- d. Uploading data and monthly reports to AFMOA/SGOF.
- e. Home visitation in coordination with NPSP case manager may include:
 - (1) Assisting with home visitation activities.
 - (2) Assisting in disseminating literature, FAP materials and referral information.

3. Team:

The FAPA and Tech manage the administrative and reception component of the FAP/NPSP, ensuring an efficient customer-oriented program. They manage the NPSP record system and may assist the NPSP team with prevention activities, such as community education programs and briefings.

The FAPA and Technician prevention responsibilities at the team level include:

- a. Ensuring records are centrally located for easy access and maintained for the NPSP team.

- b. Reviewing records periodically, ensuring all paperwork is complete and signed.
- c. At opening of an intensive services case, preparing record for home visit, ensuring all documentation is included in the record, labeled, and stamped for use by providers.
- d. Maintaining a prevention log for all participants of NPSP (both community and intensive services participants) and assigning NPSP ID numbers.
- e. Organizing community/education packets of information for the initial home visit. Packet may include educational materials, NPSP publicity and promotional material, and community resource information.
- f. Participating in NPSP team case staffings.
- g. Ensuring compliance with MTF Personnel Reliability Program (PRP) procedures for active duty members on PRF status (see Chapter IVF).

4. Community:

The FAPA and Tech will often be the first point of contact a prospective participant has with NPSP. EVERY contact with prospective participants is a marketing opportunity. Therefore, the FAPA and Tech must be extremely knowledgeable about all programs and services available to young families both on and off the installation. In addition to providing administration management, they may also assist the prevention team in preparation and presentation of a variety of prevention programs.

The FAPA and Tech prevention responsibilities at the community level may include:

- a. Briefings.
- b. Educational Classes.
- c. Support Groups.
- d. Health Fairs/Open House.
- e. OB Orientation.
- f. Parent/Child Interaction Program.
- g. Creating and distributing marketing materials to publicize NPSP.
- h. Participating in IDS prevention sponsored activities.

5. Staffing Considerations:

The administrative and reception tasks of the FAPA and Tech are vital to the efficient operation of the NPSP team. Therefore, management of records, scoring of assessment tools and follow-up calls to perspective participants are required tasks. The additional tasks described are dependent on staffing resources, skill and interest level of the FAPA and Tech, and the NPSP needs at each installation. Home visiting and outreach activities are contingent on FAPA's/ Tech's availability and expertise to engage in these activities.

Chapter VI

NPSP Resources

The following resource information is offered to assist you in providing NPSP services to families. These are only a few of a wide range of products to consider using for your program.

Potential Funding for Educational NPSP Resources:

- Brooks Resource Account (See FAP Resource Guide for information) of \$1,000 at each FAP Base.
- Medical Group Prevention Committee funding. Check with flight Commander or ask the RMO at hospital/clinic
- Hospital/clinic educational funds
- Health and Wellness Centers (HAWC) prevention funds might provide some support for initiatives.
- Base associations, such as Spouses' Clubs or First Sergeants' Association, or the Chapel may have funds to support special projects.
- MAJCOM Prevention initiatives sometimes include funding for special projects. Check with your MAJCOM FAP manager for information.

NPSP Link on AFMOA/SGOF Web Site

Current information is available on the SGOF web site under the NPSP link. The address for the site is: <http://sg-www.satx.disa.mil/moasgof/>. Features include an electronic version of the NPSP Manual with all forms and data collection sheets, FAQs (frequently asked questions) and the capability to submit input for posting to the site so you can share information, briefings, materials, ideas, etc. with your colleagues. Also, there is a feature that allows you to easily submit questions to the appropriate staff at SGOF that you might have about the NPSP. Other posted information can also be found. The goal for this web site is to be an easily available resource where staff can visit to share and learn from one another and find answers to questions they might have.

Educational Resources

- Monteleone, J. (1994). *Recognition of Child Abuse for Mandated Reporter*. St. Louis: G. W. Medical Publishing. (Available in your MTF FAP library.)
- Booklet from the National Committee for the Prevention of Child Abuse:
Parent-Child bonding: The Development of Intimacy
1992 by Stanley L. Greenspan
Item #702274 ISBN # 0-937906-01-8
Cost for 1-99 = \$1.105 each; cost for 100-499 = \$.72 each

Address for orders: NCPCA Fulfillment Center, 200 State Road, South Deerfield,
MA 01373
1-800-835-2671

- **Video titled “Discipline from Birth to Three”**

Morning Glory Press
6595 San Haroldo Way
Buena Park, CA 90620-3748
(714) 828-1998

- **New Dad Facts pamphlet**
Pregnancy facts pamphlet
Childbirth facts pamphlet

ETR Associates
P.O. Box 1830
Santa Cruz, CA 95061-1830
1-800-321-4407

- **Guide to Your Child's Symptoms**

141 Northwest Boulevard
American Academy of Pediatrics PO Box 747
Elk Grove, IL 60009-0747
1-800433-9016
<http://www.aap.org>

- **The Dad film video**

Injoy Videos
3970 Broadway, Suite B4
Boulder, Co 80304
303-447-2082

- **Wallet CPR cards, childproof caps**

Positive promotions
40-01 168th Street
Flushing, NY 11358
800-635-2666

- **Prenatal Breast Care**

Fathers ask questions about breastfeeding,
Breastfeeding your twins
Sleep patterns of breastfed babies
Health education Associates INC
8 Jan Sebastian Way #13
Sandwich, MA 02563-2359
888-888-8077

- **Cambridge Parenting & Family Life**
 PO Box 2153, Dept PA10
 Charleston, WV 25328-2153
 1-800-468-4227
- **Help At Home (0-3)**
 Item # 156-C English version: 540 pages of reproducible ready-to-use parent handouts to help make family involvement easy and effective. Includes activities to encourage, support, and facilitate developmental skills. 1997
 Cost for this product was \$69.95
 Vort corporation
 Po Box 60132
 Palo Alto, CA 94306
 Tel: 650-322-8282 Fax: 650-327-0747
 web site: <http://www.vort.com>
 Federal ID # 94-1738422
- **Ellyn Satter's Nutrition & Feeding for Infants & Children**
 Includes 56 handout masters covering basic nutrition & feeding; infant & older baby; and toddler & preschooler. Integrates the principles of nutrition, feeding, child development, and parenting.
 Cost \$224.00.
 Ellyn Satter Associates
 4226 Mandan Crescent, Suite 50
 Madison, WI 53711-3062
 Tel: 1-800-808-7976
 fax: 608-271-7976
 web site: <http://www.ellynsatter.com>
- **Feeding with Love & Good Sense**
 Videotape series: divided into 4 segments: the infant; the older baby; the toddler; and the preschooler. Shows the feeding issues at each stage and actual children & parents learning to feed and issues involved.
 60 minute videotape
 Cost \$164.95.
 See above for address
- **Brazelton, T.B. Touchpoints.** Vol. 1: Pregnancy ,birth, and the first weeks of life; Vol. 2 The first month through the first year; and Vol. 3 One year through toddlerhood. Three Videotapes, 45 minutes each. (Check your MTF FAP library.)
 Cost \$79.95
 Order through InJoy videos 3970 Broadway, suite B4
 Boulder, Colorado 80304
 Telephone # 303-447-2082
 Internet address: InJoyVideo@AOL.com
 federal ID# 84-0890671

phone orders 1-800-26-2082
fax: 303-449-8788

- **Sex, Love & Babies: How Babies Change Your Marriage**
30 minute videotape that lets new parents know what kinds of changes to expect.
Order through Injoy videos see address above.
Cost \$59
- **Diapers & Delirium: Care & Comfort for parents of Newborns**
27 minute videotape
Cost \$24.95
Order through Injoy videos (See above)
- **Caring for Your Baby and Young Child birth to age 5**
American Academy of Pediatrics
720 page book printed 1998 Provides guidelines and milestones for physical, emotional, social, and cognitive growth.
Cost \$15.95
Order through AAP 1-800-433-9016 or fax 1-847-228-1281
Internet site: <http://www.aap.org>
AAP Publications
PO Box 747
Elk Grove Village, Illinois 60009-0747
- **With Child** desk version
\$39.95 : a 96 page spiral bound educational tool to teach about pregnancy
Order from Childbirth Graphics by WRS
PO Box 21207
Waco, TX 76702-1207
1-800-299-3366 ext. 287
fax 1-888-977-7653
- *Honey I'm Pregnant too!*
45 minute video designed to help fathers through nine months of pregnancy. 45 minutes Cost \$19.95
Order from Childbirth Graphics (*see above for address*).
- **Breastfeeding** : Coping with the first week.
A 30 minute video that will help women breastfeed well and get off to a good start.
Has great video on how to correctly latch baby on the breast.
Cost \$79.95 from Childbirth Graphics (*above*).
- **Healthy Newborns flip chart**
67 full color image of newborn appearance, newborn procedures, and behavior.
Cost \$85.00
Order from Childbirth Graphics (*above*).

- **Drugs in Pregnancy & Lactation**
975 page book containing the most current findings from research.
Cost \$89.00
Order from Childbirth Graphics (*above*).
- **Knowing the Unborn:**
29 minute video that promotes parent-infant attachment and interaction before birth.
Cost \$ 39.95
Order from Childbirth Graphics (*above*).
- **Miracle of life**
Video 60 minutes,
Cost \$19.95
Order from Childbirth Graphics (*above*).
- **Baby Talk**
60 minute video on early parenting concerns and baby care
Cost \$24.95.
Order from Childbirth Graphics (*above*).
- **Childproof: Home Safety**
50 minute video
Cost \$50.00
Order through Childbirth Graphics (*above*).
- **Keys to Caregiving**
Tear off booklets # 1-5: *Infant State; Infant Behavior; Infant Cues; State Modulation;* and *Feeding is More than Eating*.
Cost \$16.95 for each pad of 100 booklets.
Order from NCAST
Box 357920 University of Washington Seattle, WA 98195-7920
Phone: 206-543-8528
- **The Breastfeeding Answer Book**
Spiral bound 608 pages, resource for counseling breastfeeding mothers.
Cost \$52.00
Published by la Leche league PO Box 4079 Schaumburg, IL 60168-4079
Phone # 1-847-519-7730
Internet site www.lalecheleague.org
- **The Expectant Father**
Video 45 minutes produced for dads by dads, answers questions and alleviates fears.
Cost \$14.95
Order from la leche league (*above*).

- **How Big is My Baby**
Handout chart showing actual size of baby at different weeks of pregnancy.
Cost \$6.40 per set of 20.
Order from The Learning Curve 4614 Prospect Ave #421 Cleveland, OH 44103-4314 phone # 1-800-795-9295
- **Young Children**
Parenting 1,2,3,4 (Book) Copyright 1996
Active Parenting Publishers
810 Franklin Court, Suite B
Marietta, GA 30067
- **Active Parenting Today** (Video based Parenting programs, Age 2-12)
Copyright 1993
Active Parenting Publishers
810 Franklin Court, Suite B
Marietta, GA 30067
1-800-825-0060
- **1-2-3 Magic** (Book/Video, Ages 2-12)
Dr Thomas W. Phelan
1990 Child Management, Inc.
Glen Ellyn, IL
1-800-442-4453
- **Early Childhood STEP** (Video and Print Program, Children under age 6)
(Systematic Training for Effective Parenting)
Don Dinkmeyer, Sr
Gary D. McKay
James S. Dinkmeyer
Don Dinkmeyer, Jr
Joyce L. McKay
American Guidance Services, Inc.
4201 Woodland Road, P.O. Box 99
Circle Pines, Minnesota 55014-1796
1-800-328-2560

Couples Communication

- **Couple Communication** (Video and Printed Material Program)
Copyright 1992
Sherod Miller
Phyllis Miller
Elam W. Nunnally
Daniel B. Wackman
Interpersonal Communication Programs, Inc.
7201 South Broadway
Littleton, CO 80122
(303) 794-1764
- **Prevention Relationship Enhancement Program** (Video and Printed Material)
Copyright 1996
Howard Markman
Scott M. Stanley
Susan L. Blumberg
PREP Educational Products, Inc.
P.O. Box 102530
Denver, CO 80250-2530
1-800-366-0166
- **Fighting For Your Marriage** (Book)
Copyright 1994
Howard Markman
Scott Stanley
Susan Blumberg
Jossey – Bass Inc.
350 Sansome Street
San Francisco CA 94104
(415) 433-1740

APPENDIX A. GLOSSARY

USAF FAMILY ADVOCACY PROGRAM NEW PARENT SUPPORT PROGRAM

Accessible Community Program – Programs that are located and scheduled to the convenience of the focus population, have minimal or no waiting lists, and have minimal if any cost. Programs for young families should accommodate the presence or the schedules of young children.

Active Record – An open record in the FA office which reflects that a client/participant has had a face-to-face office or home visit with a FA Nurse or FA Treatment Manager (other than in a group or class) within the last 30 days.

AFMOA/SGOF – Air Force Medical Operations Agency. The AF Medical Operations Agency is a part of the Surgeon General's office. The Family Advocacy Division (SGOF) is part of AFMOA and is located at Brooks AFB, TX.

Allegation - A report that maltreatment may have occurred.

Assessment – Application of diagnostic methods to evaluate, analyze critically, and judge definitively the nature, significance, status or merit, importance or size of a need, problem or issue. A biopsychosocial clinical assessment is accomplished through interviews, questionnaires, and reliable collateral information.

Case Manager – NPSP staff member with primary case responsibility to coordination of treatment and services provided to families from entry to exit from the FAP maltreatment intervention system.

Central Registry – A central management information system maintained by each branch of the Service for identifying and recording information on substantiated incidents of child and spouse maltreatment. The AF FAP Registry is located at AFMOA/SGOF, Brooks AFB, TX.

Community Resilience – The ability of a community to achieve better-than-expected outcomes in the face of adversity. Resilience is enhanced by community cohesion and social capacity. Community cohesion involves individual identification with and sense of psychological connection to others in the community. Social capacity is a community's ability to bring members together and create a psychological sense of connection in order to develop resources and opportunities for meeting the individual and collective needs and goals of members.

Contact Activity File – A system for storage of the FNS package when

- the FNS score indicates the family is “low needs,” not requiring home visits **OR**
- when the FNS score indicates “high needs” but
 - a) the family is assessed on home visit not to have high needs **OR**
 - b) the family has declined the offer of home visits.

The Contact Activity File may be located in an “accordion file” or file cabinet drawer, apart from maltreatment records, under double lock. FNS packages can be filed alphabetically or by date of last contact.

Core Measures – The key NPSP instruments used with *all families receiving home visits*. These are the

- HOME (Home Observation for Measurement of the Environment),
- PSI (Parenting Stress Index-Subscales) (“Parenting Index”), and the
- ASQ (Ages and Stages Questionnaire).

Additional measures, such as the Drinking Habits Inventory or Resolving Parent-Child Conflict questionnaire, are used when answers on the Family Needs Screener (FNS) or the PSI indicate there are potential special concerns for the family. (See NPSP Manual, Chapter 4G.) (NOTE: The Family Needs Screener is used with all prospective NPSP participants. It is not included in the Core Measures list because it is assumed that the participant will have already completed the FNS package.)

Early Intervention Services – A multifaceted program mandated by public Law 102.119 to identify and provide services to infants and toddlers with disabilities and their families. Each state is mandated to have an Early Intervention Program. Military medical facilities are responsible for the program where there are DoDDS overseas or Section 6 schools in CONUS.

Educational and Developmental Education Services (EDIS) – Clinics overseas that are part of the MTF to provide early intervention and medically related services (previously known as AFSEC).

Exceptional Family Member Program (EFMP) – AF program that identifies eligible DoD families with exceptional medical, mental health, or educational needs, assists those families in obtaining required services and verifies the availability of required services at the time of reassignment.

Family Dynamics - The constellation of factors associated with family relationships that affect the nature of those relationships and the outcomes for family members. Examples include power and control issues, communication patterns and blockages, educational or cultural barriers, and expectations based on family-of-origin experiences.

Family Needs Screener (FNS) – The assessment tool developed by the University of New Hampshire to screen prospective participants of the USAF NPSP in order to determine their level of need and the appropriate level of intervention.

FNS Package (also called “screener package”) – The initial three forms completed by prospective participants of NPSP upon first contact with NPSP as a way to identify the family’s level of need, determine the appropriate interventions, and locate the family for a follow-up contact. These are the

- Family Information Form,
- How Can We Help? Form, and
- The Family Needs Screener

FOB – Father of baby

Family Service Plan (FSP) - Comprehensive outline of care to be delivered to attain expected outcomes. Two separate documents: one, located on the lower half of the Contact Form, is used to document educational and support services a family receives from the community services component of NPSP when the family will not be receiving ongoing home visits. The second FSP form is used with families receiving both community services and home visiting services. The family goals and interventions unique to the intensive service component are outlined in greater detail on this FSP.

First-time Parent – A family in which the mother and/or father are first-time parent(s) or the child is the first child of the current relationship, even if both mother and/or father have a child or children from previous relationships.

Focus Population – The population or group for which a program was designed. The New Parent Support Program is designed for active duty families with children birth to three years or pregnant spouses.

Home Visit – A face-to-face contact with a participant(s) of NPSP, in the participant’s home, by a member of the NPSP team, for the purpose of assessment **OR** assisting the participant in attaining established goals.

Integrated Delivery System (IDS) – A multidisciplinary team of helping professionals representing six matrixed base agencies, collaborating to provide seamless prevention and quality of life services to Air Force families and the community.

Intensive Services – The package of services characterized primarily by the home-visiting component offered to prospective participants who are identified as having “high needs” on the FNS and other assessment tools/techniques. Intensive services also include referrals for other clinical or community services (e.g., financial counseling), but the hallmark of intensive service is ongoing home visits directed toward goals and objectives developed in collaboration with the participant family.

New Parent Support Program (NPSP) – A universal program that offers community-based and home-based family maltreatment prevention services to families with infants and toddlers and is staffed by nurses, social workers and program assistants.

NPSP Clinician – FAN or FATM providing direct services to NPSP participants.

NPSP Log – A system of entering each prospective NPSP participant into a chronological list of prospective participants once they have completed the FNS package. Direct referrals from command or other agencies may be entered into the log before the FNS package is completed.

NPSP Participant – A member or family of the focus population for the NPSP who has accepted community services or NPSP home visits.

Nursing – The diagnosis and treatment of human responses to actual or potential health problems.

Nursing Assessment – A systematic, dynamic process by which the nurse, through interaction with the client, significant others, and health care providers, collects and analyzes data about the client. Data may include the following dimensions: physical, psychological, sociocultural, spiritual, cognitive, functional abilities, developmental, economic and life-style.

Nursing Diagnosis – A clinical judgement about the client's response to actual or potential health conditions or needs. Diagnoses provide the basis for determination of a plan of care to achieve expected outcomes.

Nursing Evaluation – The process of determining both the client's progress toward the attainment of expected outcomes and the effectiveness of nursing care.

Nursing Implementation – May include any or all of these activities: intervening, delegating and/or coordinating. The client, significant others, or health care providers may be designated to implement interventions within the Family Service Plan (nursing plan of care).

Open Record – A FA record which contains a signed informed consent and other family-specific information for the purpose of creating a chronological history of contact with a family who is identified as having a need for FA intervention. The record is open as long as the family is receiving FA services.

Outcomes: Measurable, expected, client-focused goals.

- **Intermediate** – Direct program effects that should be apparent on completion of the program. Intermediate outcomes can be measured with a pretest-posttest design. These outcomes include increases in knowledge and skills or changes in attitudes.
- **Proximal** – Short-term program effects or impacts, such as a decrease in prevalence of child abuse.
- **Distal** – Long-term effects or impacts of the program, such as enhance mission readiness or healthier AF communities.

PNFOB – Partner, not father of baby

Prospective Participant – A member or family from the focus population who has not yet accepted NPSP services.

Secondary Prevention Counseling Services - Educational, supportive and therapeutic interventions provided by a FATM or FAO, to an active duty family, not currently enrolled in NPSP or having an open maltreatment record, where there has been an assessment, using specified instruments and a clinical interview, of substantive risk of maltreatment. Services are documented in the Secondary Prevention Record.

Secondary Prevention Record (SPR) - Record for documentation of Family Advocacy prevention services to military families considered to be “high needs” which places them at higher risk of family maltreatment. These families are enrolled in the NPSP or receiving Secondary Prevention Counseling Services.

Standards of Nursing Care – Authoritative statements that describe a competent level of clinical nursing practice demonstrated through assessment, diagnosis, outcome identification, planning implementation, and evaluation.

Standards of Nursing Practice – Authoritative statements that describe a level of care or performance common to the profession of nursing by which the qualities of nursing practice can be judged. Standards of clinical nursing practice include both standards of care and standards of professional performance.

Appendix B. Key AF FAP Standards Relevant to the NPSP

NEW PARENT SUPPORT PROGRAM (NPSP)

JUL 99

P-10

P10.1 Where a full-size Family Advocacy Core team is available, the Family Advocacy Prevention team will develop and manage the New Parent Support Program (NPSP) which utilizes universal services to address the prevention of maltreatment in military families with pregnant spouses and/or children aged birth to three years. The NPSP is also designed to build healthy communities, and to enhance mission readiness. The attached NPSP Logic Model is used to ensure NPSP services are focused on achieving these goals. The attached NPSP Flow Diagram gives an overview of NPSP processes. For program details, see the NPSP Manual.

P10.2 The NPSP team is comprised of the Family Advocacy Officer (FAO), Family Advocacy Nurse (FAN), Family Advocacy Treatment Manager (FATM), Family Advocacy Outreach Manager (FAOM), and the Family Advocacy Program Assistant (FAPA) or Mental Health Tech (MHT).

P10.3 Eligibility requirements for participation in the New Parent Support Program will include the following:

- a) One of the parents is eligible for military medical care*, AND
- b) One of the following categories is met:
 - 1. The family has a child under the age of three years or a spouse who is currently pregnant.
 - 2. Individuals and/or couples who are anticipating marriage that will create a new family with children under the age of three.
 - 3. Individuals and/or couples anticipating the adoption of a child under age three.

(*Families of retired sponsors may receive services on a space-available basis.)

P10.4 Participation in the NPSP is voluntary.

P10.5 NPSP staff will market the NPSP to the focus population and potential referral sources, such as unit leadership, military and TRICARE medical providers, and staff of other installation and civilian community agencies.

P10.6 NPSP staff will ensure completion by prospective NPSP participants (primary caretaker or pregnant spouse) of the Family Needs Screener (FNS; developed for especially for the AF NPSP by the University of New Hampshire Family Research Lab), Family Information Form and How Can We Help? Form, referred to as the FNS package. Families who refuse to complete paperwork may be referred for community services and receive up to two (2) home visits. To receive ongoing home visits, at a minimum, the FNS, Family Information Form and FAP Informed Consent-Prevention Form must be completed. (See NPSP Manual for guidelines.)

P10.7 Prospective participants who complete the FNS package will be entered in the NPSP log so that the response to these prospective participants can be tracked. Referrals from unit leadership, other agencies or professionals may be entered into the log prior to completion of the FNS package.

P10.8 All families completing the FNS package will be contacted and offered, at a minimum, community services. A Family Service Plan will be completed for all families who agree to participate in the NPSP. Families who screen as having "high needs" for services will be offered a home visit from a Family Advocacy Nurse (FAN) or Family Advocacy Treatment Manager (FATM).

P10.9 Community services available to all NPSP participants will include, at a minimum, programs and activities that address

- a) Parenting Education,
- b) Parent-child Interaction Group(s),
- c) Couples' Communication and Problem-Solving Skills, and
- d) Parent Support Services.

The NPSP team will work collaboratively with the installation Integrated Delivery System (IDS) and other community resources to ensure these services and activities are available and are designed to enhance the resilience of the community of NPSP-eligible families. The Family Advocacy Outreach Manager (FAOM) will be the principle FAP liaison to the IDS for NPSP issues. (See Std. P-2 and the NPSP Manual.)

P10.10 Families receiving one or two initial home visits will receive a clinical assessment interview from the NPSP clinician, and completion of the Parenting Index, Home Observation and Measurement of the Environment (HOME) Inventory, and Ages and Stages Questionnaire IAW guidelines provided by AFMOA/SGOF. Additional questionnaires (Mood Inventory, Resolving Couple Conflict Scale, Resolving Parent-Child Conflict Scale, Drinking Habits Inventory, Index of Marital Satisfaction) will be used when potential special needs are identified on the FNS, Parenting Index or clinical interview. (See NPSP Manual.)

P10.11 The cases of all families who screen as "high needs" on the FNS and/or receive initial home visit(s) will be staffed within 30 days of the first home visit at the Team Case Staffing meeting of the NPSP team, chaired by the Family Advocacy Officer (FAO) and occurring at least monthly. The team will review assessment information, determine whether the family has high needs, and recommend services for the development of the Family Service Plan. After initial review, the team will review the cases of families receiving intensive services at least annually. Case staffings will be documented on the family's Case Staffing Form, and SF600 (when needed). Agendas for Team Case Staffing meetings, annotated with the cases discussed and initials of NPSP staff participating, are kept on file for one year and then destroyed.

P10.12 All families who are assessed by the NPSP clinician home visitor and NPSP team to have high needs will be offered intensive NPSP services. The NPSP clinician will work with family members to develop a detailed Family Service Plan (FSP) based on their joint assessment of family need, and recommendations from the Team Case Staffing.

P10.13 Intensive NPSP services will include:

- a) ongoing home visits by the FAN and/or FATM, and possibly other NPSP team members as needed, and
- b) referrals, as appropriate, for community services open to all NPSP families, and
- c) referrals for specific services from IDS and other agencies (e.g., financial counseling, mental health care), as indicated
- d) documentation of services, ongoing assessment, family progress, effectiveness of interventions in the Secondary Prevention Record (SPR).

P10.14. Assessment, contact and services to families who receive no more than two home visits and are not assessed as having high needs will be documented on the appropriate forms (NPSP Contact Form, NPSP Case Staffing Form, NPSP Data Summary Form, SF600), stapled and filed in the NPSP Contact Activity File. Documentation of NPSP services in either format is destroyed two years after last contact with the family.

P10.15. Secondary Prevention Records may only be transferred by written request of the family after arrival at a new duty station. The written request with participant signature is sent to the losing NPSP by the gaining NPSP staff.

P.10.16. All NPSP families receiving intensive services will be asked to repeat the measures they have taken every six months and at case closure, with the exception of the Ages and Stages Questionnaire, which will be repeated when children under three in the family reach the age milestones for which forms have been developed. If the participant has completed the questionnaires within the last 60 days, she or he will be asked only to complete the FNS at case closure. (See NPSP Manual for further details.)

P10.17. Cases of high needs participants receiving intensive services are closed when one or more of the following criteria are met:

- a) Participants have met agreed upon goals.
- b) The participant request voluntary withdrawal from the program.
- c) Participant with an open NPSP record is leaving the base.
- d) Participant becomes ineligible for military benefits.
- e) The participant becomes involved in a substantiated maltreatment case. (NPSP services may continue, with documentation, continued, in the maltreatment record.)
- f) Participant has failed to keep several appointments and/or NPSP staff have lost contact with the participant.
- g) The youngest child reaches his or her third birthday.
- h) There is fetal demise or death of the infant or child, and no children under age three remain in the family.

P10.17. Families who no longer meet criteria for the NPSP may receive Secondary Prevention Counseling Services (See Std. P-11) on a space-available basis as long as:

- a) Family members are assessed to have high needs and there is ongoing risk of maltreatment.
- b) Family members receiving services are eligible for military benefits.

CONSIDERATIONS:

The New Parent Support Program should be tailored to the installation's needs and circumstances. In collaboration with the installation IDS and as part of the ongoing FAP prevention community assessment and services development process, the NPSP team conducts ongoing community needs assessment and identification of available services for the focus population, namely,

- active duty families with pregnant spouses and/or children ages birth to three years, or
- eligible beneficiaries anticipating becoming members of families with children aged birth to three years.

The FAP Core Team consists of the Family Advocacy Officer, Outreach Manager, Nurse, Treatment Manager, Assistant, and Mental Health Technician where available. At some small locations less than a full team is authorized by AFMOA/SGOF. In particular, if a Family Advocacy Nurse is not assigned, the NPSP will not be fully implemented. Consult with the AFMOA/SGOF Nurse Program Manager for guidance.

The principal focus of the NPSP is the prevention of maltreatment in families in the focus population. When maltreatment is prevention, AF communities become healthier and the mission is supported. Services consist of community services that meet the needs of the focus population, information and referral services, and for families assessed to have high needs, ongoing home visits with referrals for additional services in specific need areas.

Prospective participants may self-refer, be referred by unit leadership, other military or TRICARE medical providers, or staff from other base and community agencies. The NPSP staff is encouraged to give NPSP overviews to groups in the focus population, such as attendees at OB Orientation. Prospective participants who complete the FNS package are entered in the NPSP log and receive follow-up phone calls from members of the NPSP staff.

Mothers and primary caretakers will be strongly encouraged to complete the Family Needs Screener (FNS). The FNS can be administered by any member of the NPSP team. Prospective participants scoring in the “high needs” category are offered home visitation from the FAN and/or FATM. The level of services provided should be appropriate to level of assessed risk. Other instruments are used with participants receiving home visits, as noted above and detailed in the NPSP manual.

Community services must be sufficient to

- Provide adequate services in each of the key areas mentioned in P10.9,
- Be readily available to, and
- Tailored to the needs of the focus population.

The NPSP team, in collaboration with the IDS, surveys the local base and civilian community services that are appropriate for NPSP participants. Where service gaps are identified, the IDS should develop program alternatives. Community services may include activities such as support groups for single parents, fathers, teens, and new parents, educational classes, and parent-child interaction groups such as “Moms, Pops & Tots” or “A Time for Us.” (See Appendix E for suggestions.)

Marketing for NPSP is done in collaboration with the FAP Team and the IDS. The NPSP marketing plan can be a part of the FAP Prevention marketing plan. (See Standard P-6).

If the prospective participant scored as “low needs” on the FNS, she or he is offered community services appropriate to her or his needs, as indicated on the How Can We Help? Form and discussion with the prospective participant. In this case, the Family Service Plan of community services offered and accepted is documented on the NPSP Contact form. The Contact Form is also used to document the Family Service Plan for families who received up to two home visits, were assessed as having low needs for further services and were referred to community services.

When a family has been screened or assessed as low needs and received no more than two home visits, the forms completed by and on the family are stapled and filed in the Contact Activity File, an accordion file or file drawer. The documentation may be filed alphabetically or by date of last contact. The stapled package is destroyed two years after date of last contact with the family.

Home visitation represents an important intervention tool from the array of universal services that will be offered to NPSP families. Moving the site of services from the clinic office to the client’s home has been proven by research to improve the treatment potential of the NPSP. The home visit allows the FAN and the FATM to make clinical observations of family members in their home environment. Relationship building is enhanced when the NPSP team member is willing to meet the family on “their turf” with fewer controls and constraints than in the clinic office. The assessment process and interventions can then be tailored to the family’s unique environment. Effective home visits create linkages with families who may not accept more customary interventions.

All families who screen as “high needs” on the FNS or who receive home visits are staffed within 30 days of initial home visit at the team case staffing meeting, chaired by the FAO, a clinical case staffing conference which occurs at least monthly. The team discusses the results of the home visit assessment and instruments used, and develops a set of recommended services for the family. Families receiving ongoing home visits will have their cases reviewed by the team at least annually. Of course, when there is a clinically or politically complex case, the team may discuss the case more often.

Families who are assessed via home visits as having high needs for further services and who agree to accept intensive services, including ongoing home visits, are engaged by their NPSP clinician in an active process of

- determining goals and objectives they wish to achieve,
- choosing services and interventions that would be helpful, and
- outcome measures that will indicate success in achieving their goals.

Recommendations from the team case staffing meeting on the family are considered in this process. The result of this collaboration between the NPSP participant and the NPSP clinician is the Family Service Plan. This more comprehensive plan is documented in the Family Service Plan Form and placed in the family’s Secondary Prevention Record.

The length of a home visit will vary depending upon family needs and dynamics, and should allow for adequate visitor-client interaction for assessment, intervention, and evaluation purposes. Generally, home visits should not exceed one hour (not including travel time) in duration. The home visit may be longer during the assessment process and those occasions when extended contact with the participant is deemed essential by the provider. Longer home visits should be cleared by FAO. During each home visit, FAP team members update their assessments of home environment, safety issues, family stress, family interactions, family health issues, progress toward identified goals and the need for further interventions.

Families living outside staff travel limits should be provided with information and referral to local community services. Home visits outside staff travel limits should be provided, with the approval of the FAO, only when the risk of maltreatment is very high and no other alternatives to address family needs can be found.

Instruments are useful for assessing and evaluating intervention outcomes. The Instruments that will be used in the NPSP include the Home Observation Measurement of Environment Scale (HOME), Ages and Stages Questionnaire (ASQ), Parenting Index, Resolving Parent-to-Child Conflict Scale, Resolving Couple Conflict Scale, Drinking Habits Inventory, Index of Marital Satisfaction (IMS), and the Mood Inventory. See the NPSP Manual for a complete description of the NPSP evaluation protocol and duplication-ready instruments.

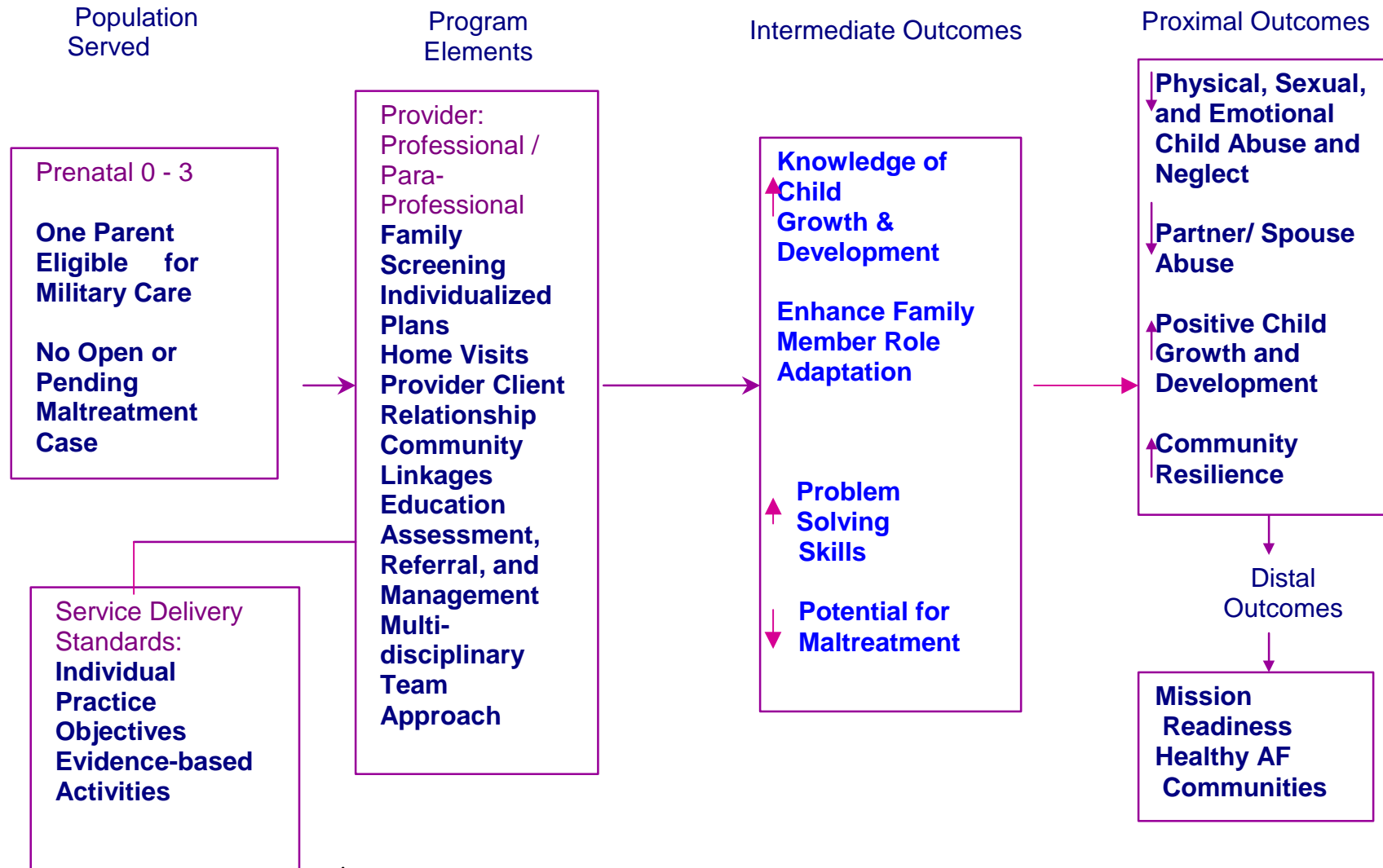
If a family has a substantiated incident of maltreatment, the Secondary Prevention Record (SPR-NPSP) is closed. NPSP services may continue with documentation recorded in the maltreatment chart. Primary maltreatment case management responsibility is always assigned to a social worker. The FAN may continue to provide services to the family. The FATM who has previously provided secondary prevention services may now provide maltreatment services if the family prefers and it is clinically appropriate.

Cases of families receiving ongoing home visits (i.e., intensive services) are closed when closure criteria are met. These families may be referred to other community services. They may also be referred for Secondary Prevention Counseling (SPC) Services when criteria for receiving services are met (See Std. P-11). An example would be an active duty family who no longer had a pregnant spouse or child under the age of three, but family members were at substantive risk of future maltreatment.

Refer to the NPSP Manual for additional information and guidance.

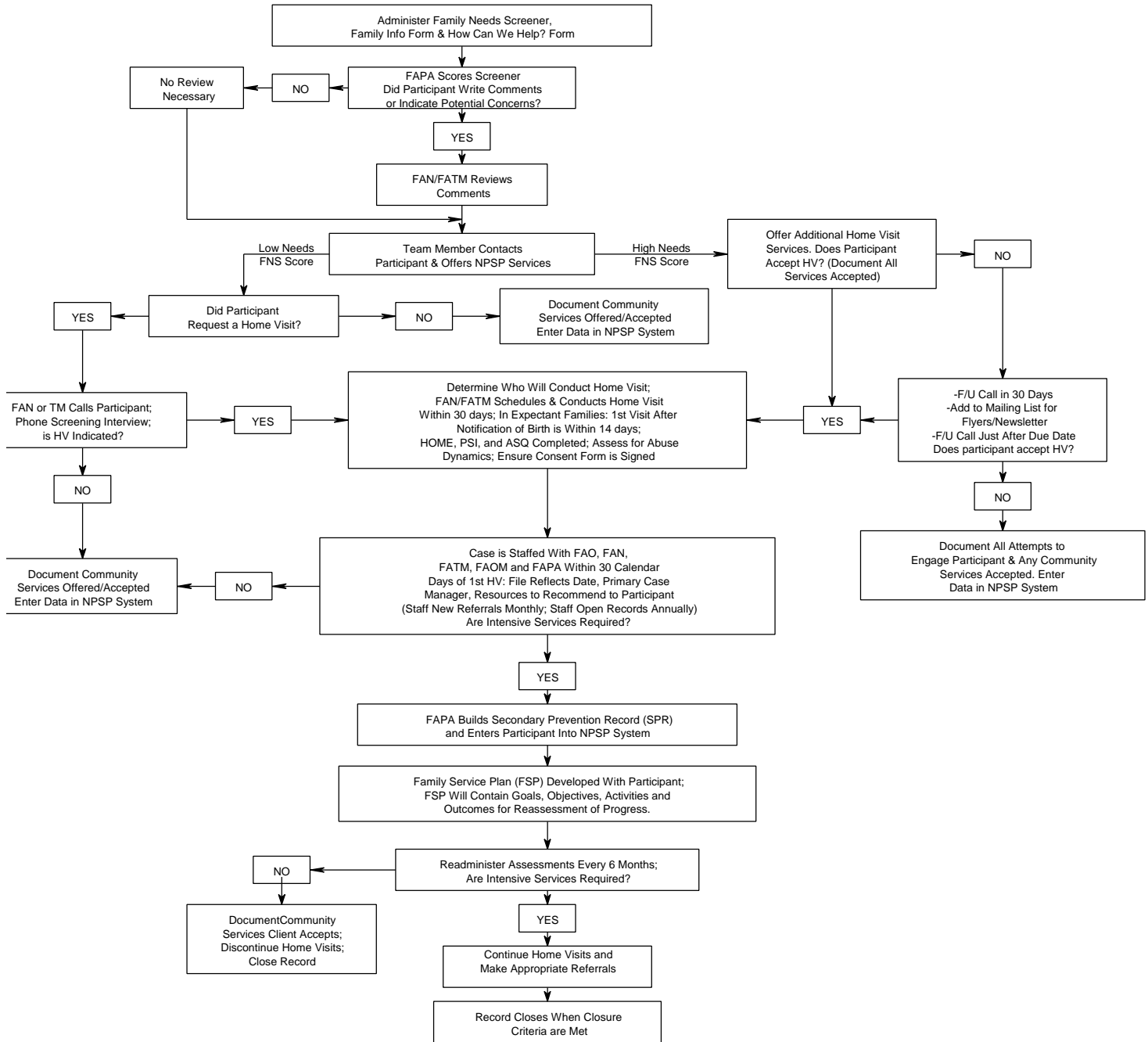
Attachment 1

New Parent Support Program- Logic Model



Attachment 2

NEW PARENT SUPPORT PROGRAM FLOW DIAGRAM



STANDARD(S):

P12.1. The quality of the FAP prevention documentation will be sufficient to allow FAP staff to:

- a. Evaluate range, depth and outcome of services,
- b. Document services to individuals and families that are based on a specific client assessment and intervention plan, and
- c. Facilitate continuity of planning and services when other FAP staff must substitute for key prevention staff members.

P12.2. Annual FAP prevention goals and service delivery plans will be documented in the FAP Prevention Plan and in Prevention Service Action Plans. The FAP Prevention Plan also includes the FAP marketing plan. The Plan includes NPSP community services availability and development, and the NPSP marketing plan. (See Standards P-4, P-5, P-6 and P-10).

P12.3. Prevention services, community organization activities, and annual training will be documented in the Outreach/Prevention Log (OPL). (See Standard P-14)

P12.4. A referral log(s) will be maintained to document referrals to New Parent Support Program (NPSP). Interoffice referral mechanisms between FAP components will be developed to ensure continuity of care. (See Standard A-16)

P12.5. Secondary Prevention Counseling (SPC) Services, and New Parent Support Program intensive services to high needs families which involve ongoing home visits will be documented in the Secondary Prevention Record. NPSP contact with families who are assessed as low needs and receive no more than two (2) home visits will be documented in the Contact Activity File. (See Standards P-10, P-11 and P-13).

P12.6. Prevention services provided by the FAN as part of the FMCMT maltreatment intervention plan will be documented by the FAN in the FAP maltreatment record.

P12.7. The FAO will ensure that Prevention reports are completed IAW AFMOA/SGOF guidance.

CONSIDERATIONS:

Care must be taken to ensure that documentation of planning and coordination of prevention activities and services is sufficient to facilitate program continuity, quality improvement, and effectiveness of the services delivered. The FAP Prevention Plan with PSAPs is the key comprehensive planning document. The OPL is then used as centrally located documentation of the planning, coordination and provision of training and other prevention services, and community organization activities. The Secondary Prevention Record is the vehicle for documenting specific clinical and other FAP support services to families where there is a specific clinical assessment that the family is at substantive risk of maltreatment and a specific Family Service Plan is developed with the family.

SECONDARY PREVENTION RECORD (SPR)

JUL 99

P-13

STANDARD(S):

P13.1. Secondary Prevention Counseling (SPC) Services and New Parent Support Program (NPSP) intensive services to high needs families which involve ongoing home visits will be documented in the Secondary Prevention Record. (See Standards P-10 and P-11.)

P13.2. Only those FAP services that are part of a Family Service Plan developed with family members receiving ongoing NPSP home visits or SPC services will be documented in the Secondary Prevention Record.

P13.3. The secondary prevention record will be established in the name(s) of all adult family members participating in the NPSP (intensive services) or receiving SPC services.

P13.3. The secondary prevention record will be stamped on the outside "Secondary Prevention Record" and include at a minimum:

- a. Privacy Act (DD Form 2005) and FAP Informed Consent-Prevention form signed by each adult family member receiving services.
- b. Program-specific Family Information Form and assessment/evaluation instruments, administered and maintained IAW AFMOA/SGOF.
- c. Biopsychosocial assessment and Family Service Plan, updated as needed.
- d. Summary of prevention activities on SF 600, completed on each clinical contact with family members. Notes include a summary completed whenever a significant change in assessment or Family Service Plan is made.
- e. Closing summary.
- f. Other relevant documentation.

P13.4 When used for the New Parent Support Program, the record will contain four parts and be stamped on the outside "Secondary Prevention Record – NPSP". The record will be organized as follows:

Part I. **ADMINISTRATION**

- Family Information Form
- Contact Form
- Informed Consent Prevention Form
- Privacy Act Statement (DD Form 2005)
- Release of Information (as applicable)

Part II. **DATA COLLECTION**

- Data Summary Form

- How Can We Help? Form
- Family Needs Screener, HOME, PSI, ASQ
- All Other Assessment Instruments
- Other relevant documentation

Part III. CASE MANAGEMENT

- Family Service Plan
- Case Staffing Form
- Consult Sheet(s) (SF513, as applicable)

Part IV. PROGRESS NOTES

- SF600s, filed most recent on top
- Closure summary on top when record is closed

P13.5. Secondary prevention activities will **not** be documented in participants' outpatient medical records with the following exceptions:

- a. **Significant clinical observations** will be documented in the secondary prevention record and on SF 513s, which will be forwarded to the appropriate service provider. Responses to SF 513 requests will be placed in the outpatient medical record with a copy in the SPR.
- b. Secondary prevention counseling services and NPSP intensive services to active duty members on Personnel Reliability Program (**PRP**) **status** will be documented in the SPR and the member's outpatient record IAW AFI 36-2104 and MTF guidance. (NOTE: Applies only to the active duty member, not his or her non-active duty family members.)

P13.6. FAP prevention education and other group services provided by members of the FAP staff to family members with open SPRs will be documented by the family's primary provider:

- a. The FATM or FAO in Secondary Prevention Counseling cases, or
- b. The FAN or FATM in NPSP intensive services cases.

P13.7. All requests for information from or copies of the secondary prevention record will be provided IAW with FAP Standard A-21.

P13.8. Secondary prevention records will be maintained by the installation FAP for two years after last contact with family members and then destroyed.

P13.9. Closed secondary prevention records will be transferred to another FAP only by written request of the participating family member(s) via the FAP staff at the family's new base.

P13.10. When secondary prevention records are closed due to a substantiated incident of family maltreatment, a written summary of NPSP interventions will be noted in the FAP record.

P13.11. Secondary prevention records will receive periodic peer review IAW MTF guidelines to ensure quality of services and documentation.

CONSIDERATIONS:

The secondary prevention record is a medical record designed to support family-specific secondary prevention services and meet professional standards. The SPR is used to document Secondary Prevention Counseling services and NPSP intensive services. The record facilitates peer review, meeting professional licensing requirements, and providing a family-focused record of services and concerns for medical-legal purposes.

SPRs used to document Secondary Prevention Counseling services may be maintained in a two-part or four-part folder. SPRs that document NPSP intensive services are marked "Secondary Prevention Record-NPSP" and must be maintained in a four-part folder. The FAP staff may use four-part folders or order six-part folders and staple the two inner leaves together, resulting in a four-part record.

Significant clinical observations, documented on SF 513s, include serious infection, illness, injury, deterioration in mental status, or significant changes in family risk factors. The SF513 is used to request from another provider an assessment of the observations, conditions or concerns and treatment (as appropriate). The original SF513 is filed in the outpatient record and a copy is maintained in the SPR.

Other relevant documentation may include: teaching sheets, written interoffice referral mechanisms for other FAP services, and documentation from other agencies, such as individualized education plans (IEPs).

APPENDIX C. THE FAMILY NEEDS SCREENER TOOL DEVELOPMENT

I. Background

The family needs screener tool was developed by Glenda Kaufman Kantor and Murray A. Straus of the Family Research Laboratory, University of New Hampshire. The screener was developed to help Family Advocacy make decisions on the allocation of services based on family needs, to provide a means to better assess, plan and conduct clinical interventions for the New Parent Support Program families, and to provide a more acceptable means of assessing family well-being at program entry and exit.

The tool is based on an analysis of data completed by Air Force families using a stress checklist, families receiving prevention services from the U.S.A.F. F.A.P., and on literature which identifies the major domains considered to be risk factors for family violence in the field. The screener is unique in its inclusion of stressors and family characteristics which are associated with an increased likelihood of both child and partner abuse. It includes areas of need such as single parenthood, social isolation, family history of violence and neglect, individual level stressors such as low self esteem, substance abuse, depression, and distress, and current relationship discord. A table is provided for you to illustrate the particular domains of need which are covered by the Family Needs Screener form. Column three of the table, labeled “Needs Domain” shows the area of need, along with the associated item numbers. For example the “Violence Approval” Subscale includes Items 28, 29, 30, 31.

The USAF Bases and Pilot Tests

Two consecutive pilot tests were conducted in 1999 on a total of over 700 USAF families receiving services from Family Advocacy at several bases around the world. The pilot tests were considered successful, and the screener was well regarded by staff and families.

We appreciate the support and assistance of FAP staff at the following USAF bases:

Eglin

Elmendorf

Hurlburt

Offutt

Lackland

Offutt

Patrick

Ramstein

Seymour Johnson

Tinker

FAMILY NEEDS SCREENER DOMAINS

Section	Items	Need Domain	Measure
I. Demographic			
Military	2 items: Mother's & Father's Military Status (1, 2)	Military status	USAF FANS Closure Form Item
Family	3 items: Marital Status; Living situation Example: "If married, how long?" (3,4,5)	Marital status	USAF FANS Closure Form Item
Family	3 items: Maternal Status: (antepartum or postpartum); gestational age (6, 6a, 7)	Maternal status	USAF FANS Closure Form Item
Family	2 items: No. of children; Blended family Example: "Are there children from prior relationship?" (8,9)	Family composition	USAF FANS Closure Form Item
Age	2 items: Age in Yrs. (10,11)	Age of both parents	Standard Survey item
Ethnic group	2 items Example: "Which of these ethnic groups do you consider yourself?" (12.1, 12.2)	Ethnicity of both parents	Standard Survey Item
Education	2 items Example: "What is the last year of school that you have completed?" (13.1, 13.2)	Education of parents	Standard Survey Item
II. Substance Abuse			
Alcohol consumption	3 items Example: "I sometimes drink enough to feel really high or drunk." (26-28)	Problem drinking patterns (self & partner)	Substance Abuse Scale (PRP, 1998, Kaufman-Kantor, Straus, DeVoe, Mouradian, & Pooler)
III. Family of Origin Violence & Neglect			
Violent socialization	3 items Example: "I was spanked or hit a lot by my mother or father." (33-35)	Experienced or witnessed corporal punishment and / or family violence	Violent Socialization Scale (PRP, 1998, Straus, Mouradian, & DeVoe)
Neglect history	2 items Example: "My parents did not comfort me when I was upset." (36,38)	Emotional needs	Neglect History Scale (PRP, 1998, Kinnard, Williams, & Straus)
Early years	1 item Example: "I have unhappy	Personal history	USAF Family Assessment Checklist (1997)

	memories of my childhood.” (37)		
--	------------------------------------	--	--

Section	Items	Need Domain	Measure
IV. Relationship Distress			
Marital discord	5 items Example: “My partner treats me well.” (17-20,23)	Relationship climate with spouse, partner	Family discord
V. Support Systems			
	10 items Example: “I have few friends/family to help with the baby.” (24,25,39,45-51)	Social support; Material, Spousal; Social isolation	USAF Family Assessment Checklist (1997) Other Soc. Support Measures
VI. Stressors			
Stress and pregnancy-related stress; loss of control	5 items Example: “This is an unplanned pregnancy”; “This is not a good time for me to have a baby.” (14-16,21,22)	Stress and pregnancy-related stress	USAF Family Assessment Checklist (1997)
VII. Self-esteem			
Psychological health	5 items Example: “I frequently feel as if I am not as good as others.” (40-44)	Self-esteem	USAF Family Assessment Checklist (1997), Rosenberg Self Esteem Scale
VIII. Depression			
Psychological health	4 items Example: “There are times when I feel life is not worth living”; “I feel sad quite often.” (52-55)	Dysphoria (hopelessness; sadness)	USAF Family Assessment Checklist (1997) Other Survey Items
IX. Prior Fam. Violence			
	2 items (Prior Maltreatment Case) (56,57)	Family violence	

II. RESULTS OF THE PILOT

Data collected from screeners were analyzed to establish cutting points for deciding whether families could be categorized as low or high needs families. An initial cutting point of “9” was established based on data from a preliminary pilot conducted on 100 FAP families. The cutting point was again found to be valid for a larger sample of over 600 families screened during a full-scale pilot. We concluded that the screener was a valid and acceptable means to make decisions about the allocation of resources in the New Parent Support Program. For example, the results of the pilot showed that use of the established cutting points would categorize (approximately) the following types of families as high needs:

New Parent Support Program Getting Started

Welcome to the New Parent Support Program (NPSP). You are now a part of a new and exciting team offering prevention services to military families. Being a part of this program can be very rewarding, as you will have the opportunity to meet new families who are eager to improve their parenting skills. Your interaction with a family will last a lifetime. You have the opportunity to work with families, and together will participate in helping them to acquire knowledge that leads to empowerment and improve outcomes focused in preventing family maltreatment.

The term home-visiting has a warm inviting feel to it. But if you are new to your position, it can be a little daunting. Getting started on the right track is all about preparation and a big dose of self-confidence. For every new position that you undertake, an orientation period is standard and this is no exception.

Begin first by orienting to the Family Advocacy Program as a whole.

- ◆ Schedule time to view the FAP video marketing tapes and Welcome to FAP CD ROM, check with your FAO or NCOIC
- ◆ Meet one-on-one with each program element to improve your understanding of services
- ◆ Understand how to report maltreatment and what happens to families that are reported.
- ◆ Attend an FMCMT meeting to observe the process at your base.
- ◆ Call NPSP Manager at AFMOA
- ◆ Learn the Command Structure
- ◆ Know the Base Mission
- ◆ Read the NPSP Operating Instructions (OI)

The next step is to develop a working knowledge of the New Parent Support Program.

- ◆ Review closed records of previous FAN to get a feel for the program and home visiting
- ◆ Update your knowledge of the peri-natal period from pregnancy to age three: read, read, read!
- ◆ Review Prevention Service Action Plans (PSAPs) and lesson plans for classes/groups offered.
- ◆ Contact another base for support and assistance as needed
- ◆ Ask the other installation NPSP team member to demonstrate how to market the program to an individual or family
- ◆ Examine all program handouts and view all videos used with families
- ◆ Experiment with program forms and screening instruments to improve understanding
- ◆ If needed, take a breastfeeding continuing education course or understudy with OB nurse

The final step involves acquiring a knowledge of community services in your area

- ◆ Learn about the health care system for peri-natal and pedi families (Tricare, OB care, Peds care)
- ◆ Learn about marital counseling available to families and how to access services
- ◆ Meet with Air Force Aid Representative to learn how breast pump rental system works
- ◆ Explore other services offered by Family Support Center at your location
- ◆ Learn about the process a participant would undertake to file for child support recovery
- ◆ Know how to refer families to the Women, Infants and Children's Program (WIC)
- ◆ Attend an Integrated Delivery System (IDS) meeting at your base

Knowledge is power and does wonders for your self-esteem. Once you start home-visiting you will quickly get comfortable with this wonderful world of home-visiting. Your first visit is like getting into a swimming pool. You always get use to the water temperature the faster by just diving in. As you continue to swim, the water begins to feel better and better and you wonder why you thought it was so cold! It is the same with home-visiting, you might be nervous at first but it quickly becomes very comfortable. Families are extremely grateful for the services you provide and that positive reinforcement is a wonderful motivator.

Pregnancy Status

- 22% of families who had a baby in the past year
- 30% of families currently expecting a new baby

Maltreatment Status

- 80% of families with current or prior substantiated family maltreatment

Needs Domains Status

- 46% family of origin violence
- 63% teen parents*
- 50% blended families
- 61% marital discord
- 58% dependent daughters*
- 67% possible substance abuse

(* automatic high needs family)

The Family Needs Screener was adopted as the key screening tool for use in the Air Force Family Advocacy New Parent Support Program (NPSP). A validation study will be conducted as part of the program evaluation component of the NPSP.

THIS PAGE INTENTIONALLY LEFT BLANK

*This **Sample OI** is designed to provide a guide for developing operating procedures for the New Parent Support Program (NPSP) at your base. Circumstances, needs and resources differ from base to base, which necessarily dictates some variation in the program. Suggested additions, to tailor this OI to your NPSP, are noted in italics.*

*The OI does not repeat what is in higher level guidance—Reference instead.
Provide enough detail to allow new staff to understand and implement the program.*

**BY ORDER OF THE SECRETARY OF
AIR FORCE**

THE OPERATING INSTRUCTION

22 June 1999

MEDICAL COMMAND

NEW PARENT SUPPORT PROGRAM

1. **PURPOSE:** THIS OPERATING INSTRUCTION (OI) establishes the implementation of the New Parent Support Program (NPSP), (IAW AF FAP Standard P-10 and the NPSP Manual) a program of service, which is based from the military treatment facility (MTF), encompasses the broader community, and provides care, education, and support to military families in the focus population.

2. **SCOPE AND APPLICATION:** The focus population for NPSP consists of military service members and their family members who are eligible to receive medical treatment in a military facility. The family has a child under the age of three or is currently pregnant. The parents are anticipating the adoption of a child under three, or marriage that will create a new family with children under the age of three. The family does not have a currently open maltreatment case.

2.1. The NPSP will utilize universal services to address the prevention of maltreatment in military families in the focus population. In addition, families assessed as having high needs for maltreatment prevention services will be offered home visits.

3. **REFERENCES:** USAF Family Advocacy Standards (A-14, A-26 & P-10 and P-12)
Air Force Instruction 40-301
AF Family Advocacy New Parent Support Manual
DoD New Parent Support Program (NPSP) and Parenting Education Draft Standards
Air Force Manual 37-139-Records Disposition Schedule

4. **RESPONSIBILITIES:** The Family Advocacy Prevention team will develop and manage the New Parent Support Program. This OI applies to all FAP staff assigned to the NPSP. Roles are specified in the NPSP manual. Unique responsibilities are noted below.

(list any specific additional NPSP duties for members of your staff)

5. **PROCEDURES:**

5.1 NPSP procedures will implement requirements in the attached Flow diagram, AF FAP Std P-10 and the NPSP manual.

5.2. Identification: includes cooperation with the MTF in participating in *OB orientation* for all expectant parents. NPSP referrals will generally come from *OB orientation (your primary referral sources)*. Parents may self-refer, be referred by unit leadership, other medical providers, or staff from other base and community agencies. NPSP participation is voluntary and may be terminated upon request. NPSP referrals are families without current substantiated cases of abuse.

5.3. Specific details for (your) Med Group are:

5.3.1. Which groups –(*OB orientation or other groups of expectant moms, young single parents...*) located (*where*) .will receive NPSP overview briefings and copies of the FNS package to complete. Briefings will be conducted by (*who?*) (FAN? FAPA? FAOM?)

5.3.2 Where will these meetings between prospective participants and NPSP staff take place ?-(*OB orientation, participants homes...*) (*Who?*) will administer the Family Needs Screeners (FNS), Family Information form and the How Can We Help form?-(FAPA? FAN? FATM?-if available...- what are staff resources at your base). (*Who?*) (FAPA?) score the screeners?

5.4. (*Who*) makes follow up contact ?-initial phone call to offer NPSP services.

5.4.1. (*Who?*) (FAPA ? MHT? or whoever is available?...) will contact “low needs” scorers to offer community services and referrals. (FAN ? FATM?) will provide phone-screening interview to “low needs” scorers who request home visitation).

5.4. (*Who?* FAPA? FAN? FATM? ...) will contact “high needs” scorers to offer **intensive services**: home visitation in addition to community services and referrals

6. Assessment of high needs screeners:

6.1. (*Who?*) (FAN? FATM?) continues with assessment of high needs scorers, within your geographic area by means of home visit, which will include clinical interview and administering of the following **required** questionnaires—HOME, Parenting Index (PSI), and Ages & Stages (ASQ) . Additional assessment questionnaires are used as prescribed by NPSP Manual.

6.1.3. Follow-up home visitation will be scheduled within 30 days of completing the FNS package; in **expectant** families a home visit is scheduled within 14 days after notification of child’s birth

6.1.4. Within 30 days (Fan? FATM?) will make follow-up phone call to “high needs” scorers who **refuse offer of intensive services**. Follow-up call will be made to **expectant** families just after due date. Document all attempts to engage participant and enter data in NPSP system.

6.1.5. (*WHO?*) the (FAN? and/or FATM?...) provide services to high needs scorers who live outside of geographic area? (Do your staff resources allow you to follow up or must you consider other **community partners?**)

7. Documentation:

7.1. (*Who?*) (FAPA? MHT?...) will set up a secondary prevention record (SPR) for program participants who are receiving ongoing intensive services. The participant will be entered into the NPSP system.

7.2. Family Service Plan (FSP) will be developed with program participant. FSP will contain goals, objectives, activities and outcomes for reassessment of progress. Assessments readministered every 6 months to support continued intensive services per NPSP manual instructions.

7.3. Record closes when closure criteria are met.

7.4. Records are maintained (*where?*) IAW NPSP manual and disposed IAW AF Manual 37-139.

7.5. Forms completed for families receiving community services and or 1-2 home visits are stapled and maintained in the Contact Activity File located (*where?*), IAW the NPSP manual and disposed IAW AF Manual 37-139.

8. Case Staffing:

8.1. NPSP Case is staffed with FAO, FAN, FATM, FAOM (and FAPA/MHT as available) within 30 days of 1st home visit.

8.2. Team case staffing meetings are held (*when?, how often?* Must be held at least monthly.

8.3. Case staffing form reflects date, primary case manager, and resources to recommend to participant.

8.4. Staff new referrals at least monthly.

8.5. Staff open records at least annually.

9. Community Services:

9.1. (*Who?*) (NPSP team members will collaborate with Family Support Center, Mental Health to identify services available and **develop** additional, needed integrated services for NPSP participants). Base IDS members can serve as primary sources for community services and referrals.

9.2. A range of community services are available to NPSP participants. Accessible services are available in the following areas: Parent education, Couples Communication and problem solving skills, parent

support, and parent-child interaction groups. See Attachment 1 for a list of current community services that serve NPSP participants.

9.3. (How is NPSP marketed?) (NPSP community services can be marketed via the base newspaper, flyers and community “Gatherings”). NPSP marketing plan will be contained in the annual FAP marketing plan.

Family Advocacy Program (*Director or FAO*)

(*Flight Chief, Commander*)

2 Atch

1. NPSP Flow Diagram

2. List of (*YOUR*) MTF community services

APPENDIX G. MARKETING THE NEW PARENT SUPPORT PROGRAM

Introduction

A. NPSP is a dynamic community-based, customer driven program. Its voluntary enrollment and focus on identifying customers' strengths to encourage family resiliency distinguish it from other community programs. NPSP concentrates on the prenatal to three years old population and recognizes that prevention efforts targeted at this age group have great potential towards building healthier communities. Its success is largely dependent on the Family Advocacy's team to adequately market the program and its benefit.

B. A wealth of literature exists about the subject of traditional or commercial marketing. To say that very little is written on the subject of social marketing, as it applies to social services, is an understatement. However, it is exactly this type of marketing that is distinct from traditional marketing and the type we will be concerned with in marketing NPSP.

C. Social marketing began as a discipline in the 1970s, when Philip Kotler and Gerald Zaltman realized that the same marketing principles that were being used to sell products to consumers could be used to "sell" ideas, attitudes and behaviors. They define social marketing as "differing from other areas of marketing only with respect to the objectives of the marketer and his or her organization. Social marketing seeks to influence social behaviors not to benefit the marketer, but to benefit the target audience and the general society (Kotler, Philip, Robert, Eduardo. 1989)." Social marketing has been used extensively in international health programs, and is being used with more frequency in the United States for such diverse topics as substance abuse and preventing unwanted pregnancies.

D. In this section you will find information that will assist your team in development of a marketing plan. The objective of this section is to present a broad view of marketing for a wide range of installations. We begin with a number of assumptions: even the smallest installations can benefit from lessons learned by larger installations; lessons on failures and adversities can be just as important as successes; and effective marketing is essential to the success of a program, regardless of the size of the installation. The materials that follow will open your mind to new strategies in marketing, help you identify new approaches and challenge long-standing marketing procedures. Sometimes when a program is young there is a tendency to take a shotgun approach to promotion. If you want to have an effective program, however, you need a plan.

Take a close look at any successful businesses and programs today, and you will find one key characteristic, “adaptability”. Adaptability is defined as “being able to adjust oneself without difficulty to new, unfamiliar, or unexpected conditions (Kotler, Philip, Robert, Eduardo. 1989).” Sometimes this may mean revamping the nature and dynamics of an entire program. This may also mean going against all conventional wisdom. You may find yourself testing a new program or service without soliciting a single input from your customer. In this age of “focus groups” and surveys it would be wise to utilize these resources, however, if circumstances at your base prevent this opportunity, use your knowledge of the community to assist with introducing your program.

Marketing NPSP cannot be accomplished in a vacuum. Identify the key organizations and stakeholders in your community and seek their expertise in designing your strategies. Awareness of NPSP will depend largely on building and maintaining relationships with others that have a vested interest in the success of your program. They will serve, not only as referral agents, but can also assist you in establishing credibility. The best advice that can be given regarding marketing is to always use a team approach (value each member of the team and encourage full participation); be creative; know your target population; remember that different education, age and ethnic groups may respond to very different marketing styles; don’t assume that because something worked last year it will work again today, and above all, have fun!

The Four “P’s” of Marketing

Like traditional commercial marketing, the primary focus of social marketing is on the consumer. The emphasis is on learning what people want and need rather than trying to persuade them to buy what we happen to be producing. Marketing talks to the consumer, not about the product. The planning process that takes this consumer focus approach into account refers to decisions about: 1) the Product, 2) Price, 3) Place, and 4) Promotion. These are often called the "Four Ps" of marketing. Social marketing also adds a few more “P’s”: “Partnership, Policy and Politics (Winston, 1985).” If you are serious about developing a marketing plan for NPSP, these elements must be considered.

A. Product

The NPSP "product" may be a range of products, ranging from tangible, physical products (e.g., books, and breast pumps), to services (e.g., classes, home-visits, and support), practices (e.g., breastfeeding, or eating a healthy diet), or intangible ideas (e.g., safety and protection of children). In order to have a viable program, people must first perceive that they have a genuine need, and that the services you provide is a good solution to meet that need.

B. Price

"Price" refers to what the NPSP customer must do in order to obtain the product. The cost may not be monetary, but instead may require the customer to give up time and effort, or risk embarrassment and disapproval by family and friends. If the costs outweigh the benefits for an individual, the perceived value of the service will be low and utilization will be unlikely. However, if the benefits are perceived as greater than their costs, chance of enrollment is much greater.

C. Place

"Place" describes the way that the program or service reaches your customer. For a tangible product, this refers to how products will be distributed—office, home, exhibits, etc. For intangible products, such as those often provided by NPSP, place is less clear-cut, but refers to decisions about the channels through which customers are reached with information or training. Another element of place is deciding how to ensure accessibility and quality of the service delivery. Time may be an important factor to consider.

D. Promotion

The nature of promotion focuses on “visibility”. This element is often mistaken as the primary component of social marketing. However, it is important to remember, based on a discussion of the previous elements, that it is only one piece. Promotion consists of integrating the use of advertising, public relations, promotions, media advocacy, personal testimonies and entertainment tools. The focus is creating and sustaining interest in the NPSP. Public service announcements or ads are one way, but there are other methods such as coupons, advertising on bags at the commissary or base exchange, media events, newspaper articles, monthly gatherings, or displays in highly traveled areas. Research and evaluation is crucial to determine the most effective and efficient vehicles to reach your target audience.

E. Other “P’s”

1. **Partnership**— is so important because the needs of a community are normally so diverse that one agency can't possibly provide for them alone. To really be effective you need to not only develop internal partnerships with the FAP team, but also with other organizations in the community. The NPSP team will need to figure out which organizations have similar goals --not necessarily the same goals--and identify ways you can work together.
2. **Policy**— NPSP and other social marketing programs can potentially do well in motivating individual behavior change, but sustaining change is difficult unless the customer's environment supports the change for the long run. Policy change may be required, and media advocacy initiatives (or strategically engaging media in increasing awareness of specific issues) can be an effective complement to your marketing plan.

3. **Politics**—sometimes the issues addressed by NPSP may be controversial. Base leadership, for example, may not always understand, or agree that it is important for both parents (when there are two parents) to be available for appointments. This may require some political diplomacy to gain access to leadership and convince them of the link of family stability to mission readiness. To get stakeholder support, or to head off potential problems at the pass your team should brainstorm possible threats to service delivery.

EXAMPLES OF WAYS TO USE THE 4 “P’s” APPROACH TO DEVELOP MARKETING STRATEGIES

An example of marketing strategies for engaging expectant Moms and Dads in NPSP might include the following:

- The product could be any three of these behaviors: commitment to seeing a physician for regular prenatal care; participation in infant care classes; and child-proofing the home.
- The price of engaging in these behaviors may include taking time off from work for appointments and classes and the monetary costs of purchasing items to make the home a safe environment.
- The place that these services are offered might be FAP, a mobile van, in the home, Family Support Center, chapel, local hospitals, clinics and worksites, depending upon the needs of the client.
- Promotion could be done through public service announcements, base marquee, mass mailings, media events or community outreach.
- Partnerships could be cultivated with the IDS, First Sergeants Group, OB/GYN, corporate sponsors (including formula companies, car seat companies), medical organizations, service clubs or media outlets.
- The policy aspects might focus on increasing access to care for expectant Moms at a time when Dads are more likely to be available for appointments, requiring on-base housing to be child-proof by design, and planning classes that are customer-focused. These issues can be raised in the IDS or CAIB meetings for coordination.
- Politically, the groups you would want to support your programs would depend upon the way you framed the marketing campaign. Some possible allies to cultivate are commanders and First Sergeants, nurses, physicians, parent groups, health organizations, etc.

Each element should be taken into consideration as the program is developed. These elements are the core of the marketing plan. On-going assessment and evaluation can help to shape and re-design your marketing efforts.

THE MARKETING PLAN

A. The marketing plan for NPSP can be accomplished in five easy steps. The Family Advocacy Outreach Manager (FAOM) is the key information specialist for the marketing plan and may produce a much more elaborate FAP marketing plan to augment the FAP Annual Plan.

STEP 1: Market Analysis

Begin by providing a clear answer to the question, “What is the business of NPSP? This is done for a number of reasons, but mostly to define your services in terms of the strengths and needs of the target population. The services you offer should be flexible enough to meet a variety of needs with the ability to adjust to time restraints. It is critical to identify the size of the population served, trends towards growth in that population and potential threats to providing services. The FAOM may help to facilitate acquisition of this data from the CBPO (Consolidated Base Personnel Office) and assist in developing strategies for utilizing this information as you develop your plan.

STEP 2: Marketing Objectives

The second task is deciding what direction NPSP wants to proceed. Essentially, you must decide, based on the data, if you should provide as much service as possible to the largest number of people; or develop expertise in a specific area and provide a specific service. You may also need to plan in a manner that helps you to gain maximum exposure, but focus on a limited number of carefully selected clients. The NPSP standards will provide guidance in making these decisions. Whatever the direction, the NPSP team must develop a general marketing goal (s) and behavior- oriented marketing objectives.

STEP 3: Marketing Strategies

This step is also critical and addresses how to carry out the goal and objective. There is literally tons of information written on this step alone, so if you get “stuck”, do not hesitate to review articles and books on this subject. Objectives can give rise to several strategies, which can help you to achieve success. This is often a time-consuming process that requires the participation of the entire NPSP team. The group’s knowledge and creativity in designing the market plan will make this a worthwhile effort. Sometimes you may have to divide the target population into subsets and market base on similar strengths and needs. Of course, using the 4 “P’s” will also assist you greatly in fine-tuning your strategies.

STEP 4: Implementation

No plan, whether for profit or non-profit organizations, can succeed without the commitment of people, time and resources. Therefore, a marketing plan for NPSP must provide for allocation of staff to collect and interpret the data necessary to develop the program, financial resources to implement the program and reasonable time frames to realize accomplishments. Financial support can come from a number of resources, therefore again; it is essential to build community partnerships. Once the marketing plans is completed and strategies are outlined the team is encouraged to use the plan. Initially, use of the marketing plan may not seem natural if you are not used to operating with such a document. **Persevere**, because it can assist greatly with clarifying roles and responsibilities.

STEP 5: Evaluation

There are many ways to gauge the effectiveness of your marketing plan. One common technique is to assign responsibility for monitoring strategies within a certain time frame (weekly, monthly, or quarterly). The evaluation must be customer-focused and this often means using a quantitative, rather than a qualitative approach. The plan should be able to be measured in numerical terms, but is not a substitute for evaluating goal statements (which should be more qualitative). Evaluation provides the information that is essential to make decisions about the direction of the program and modifications that may be required. The results can also assist in establishing credibility of the NPSP in the community, provides information on what works and doesn't work and demonstrates your effectiveness in addressing specific issues.

SUMMARY

The market is constantly changing. People forget fast and we are challenged with formulating strategies to keep pace with the needs of the customer. Effective marketing strengthens your program's identity. It is essential to the survival and growth of your program. A successful marketing plan enables you to identify the strengths and challenges in your community and gives an additional advantage of clarifying roles and responsibilities. Effective marketing always includes building partnerships and helps to establish credibility in the community. *Teamwork cannot simply be rhetoric*. When the focus is on customer outcomes and how everyone can work together to meet the needs of client it will discourage finger pointing and help members of the team to concentrate on issues, rather than personalities. Developing a successful marketing campaign can be time consuming but it is a wise investment that assists in the management of time, money and human resources.

DEVELOPING PLANNING OBJECTIVES

After you have clarified the overarching mission of your NPSP, and with your team, formulated a shared vision, the next step is developing goal(s) and objectives. Objectives refer to the desired results to be achieved by a specific time. The following list suggests ten criteria to consider for formulating objectives:

- A. **SUITABLE** – obviously, the achievement of objectives should support the basic purpose of NPSP. If an objective makes no contribution to the purpose of the program then it is non-productive. A positive contribution to purpose assures that the results are more than co-incidental.
- B. **MEASURABLE OVER TIME** – objectives should be stated in terms that disclose what is expected to happen and when. Planning is much easier when objectives are not vague. One objective for marketing NPSP might be, “*To increase enrollment in Taking care of Your Baby Classes by 15% during the first quarter*”. Objectives can be quantified by: quality, quantity, ratio, percentage, rate, or stages. Another NPSP objective might be, “To improve opportunities for parents to strengthen their parenting skills”. To quantify this objective, you could further say:

During the first two quarters six classes will be provided at the work-site. During the last two quarters training a base-wide “Parenting Conference” will be planned to address a variety of parenting issues in partnership with other community agencies.

When objectives are expressed in concrete ways for specified periods of time they can be measured more objectively.

- C. **FEASIBLE** - objectives should be possible to achieve. When you develop objectives, be reasonable and practical in expectations. Sometimes this is not an easy process. Take into consideration the size of the NPSP team, staff turnover and other roles and responsibilities.
- D. **ACCEPTABLE** – objectives are more likely to be achieved when team members agree that they represent the desired results of NPSP. Acceptance of an objective may include issues, such as: allocation of staff, time, and cost. If there is disagreement, it is unlikely that all members will pursue objectives. In addressing disagreements it may be necessary to bring in a third party to facilitate resolution.
- E. **FLEXIBILITY** - it should be possible to modify NPSP objectives in case of unforeseen events. However, objectives should not be vague and nebulous but concrete enough to give direction.

- F. **MOTIVATING** – research confirms that specific objectives increase performance and that difficult objective (if accepted) result in better performance than “easy” objectives. (Gary Latham and Gary Yukl, “A Review of Research on the Application of Goal Setting in Organizations,” *Journal of the Academy of Management*, December, 1975). When setting NPSP objectives consider ones, which are a little out of reach.
- G. **UNDERSTANDABLE** – state objectives as simply as possible. Ensure that they are understood by all. One survey of pitfalls in planning is a lack of understanding of objectives.
- H. **COMMITMENT** – when agreement is reached about objectives, clarify roles and responsibilities. Objectives cannot be achieved successfully without commitment. All FAP staff should share full commitment to the success of NPSP.
- I. **PEOPLE PARTICIPATION** – people who are responsible for meeting objectives are more likely to be motivated if they have input. There are great advantages in the collaborative process. If you expect other community agencies to participate in helping you to reach NPSP objectives, then you must give them some role in setting them.
- J. **LINKAGE** – objectives for NPSP must be evaluated to insure that they are consistent with the overall Mission and Vision of the Family Advocacy Program. If there are discrepancies, objectives must be re-examined and every effort made to achieve appropriate linkage. Objectives should also be linked to each other.

TOGETHER WE STAND...

Teamwork makes sense... so remember...

- **Success of NPSP is not exclusive to the core team**
- **Stay focused on customer-oriented outcomes**
- **Help other FAP staff to see their connection to NPSP**
- **The professional and para-professional staff is equally valuable to the success of the program**
- **Competition and self-serving interests is the surest way to program failure**

- **Depersonalize conflicts...focus on bad processes...not bad people**
- **Do process training and teambuilding exercises if warranted**
- **Bad policies can be a barrier to customer satisfaction**
- **Don't get too attached to your own opinion**

“It is not the size of the remedy that satisfies (complaining) customers but rather the promptness, responsiveness and clarity of the actions taken and expectations given”

Linda Lash

The Complete Guide to Customer Service

MARKETING PLAN WORKSHEET

Title of Program:

Name of Installation/Location:

Program Director:

1. Market Analysis

☐ Describe Your Program/Service

- describe what you will provide
- describe the benefits of your goods or services from your customer's perspective.
- emphasize special features

☐ *Describe the target market by*

- age
- sex
- rank
- educational level
- **strengths and weaknesses**
- **needs**
- **trends**

☐ *Identify Community Services*

- use research data
- assess demand for services
- strengths and weaknesses
- challenges
- assess how other community programs are doing
- describe the unique features of your program or service

2. Marketing Objectives

- describe what you will accomplish
- develop benchmarks to measure progress
- set time frames for evaluation
- assign specific responsibilities
- describe how your objectives integrate with the mission of Family Advocacy

3. Marketing Strategies

- **describe how you will carry out the objectives**
- **decide when you will introduce programs and services**
- **describe advantages of using your program from the customer's perspective (location, time, etc.)**
- **describe your target market**
- **explain how strategies will assist you in achieving program goals**

4. Implementation

- **what marketing activities will be engaged**
- **when will these activities be performed**
- **who will be responsible for these activities**
- create a list of advertising media to be used

□ Develop Marketing Budget

- what is the cost of proposed activities
- what resources are required
- what finances are allocated for advertising and promotions

5. Evaluation

- **describe how you will measure and evaluate your plan**
- **decide who will be responsible for collecting and managing data**
- **list other community resources who will contribute to your evaluation**
- **tie evaluation to performance standards**
- **describe how customers can participate in evaluative process**

- Screening Process
- Informed Consent
- Program Interventions

References

Florence, M. (ed.). (1996). *Sales and Marketing*, McGraw and Hill,

Kotler, Philip and Roberto, Eduardo L. (1989). *Social marketing: Strategies for Changing Public Behavior*. The Free Press (Macmillan, Inc) New York.

Latham, G. & Yukl, G. (1975). *A Review of Research on the Application of Goal setting in Organizations*. Journal of the Academy of Management, December.

Mannoff, R. K. (1985). *Social Marketing: New Imperative for Public Health*. Proeger, New York ,

Pride, William and Ferrell, O.C. (1975), *Marketing: Concepts and Strategies*. Houghton Mifflin Co. ,

Winston, W.J. (ed.). (1985), *Marketing strategies for social Services*. Haworth Press,

NEW PARENT SUPPORT PROGRAM

FAMILY INFORMATION FORM

DATE: _____

1. MOTHER LAST NAME: _____ FIRST NAME: _____

FATHER LAST NAME: _____ FIRST NAME: _____

2. TELEPHONE NUMBER: HOME: _____ WORK: _____

FATHER OF BABY/CHILD: HOME: _____ WORK: _____

3. HOME ADDRESS: _____

4. ARE YOU OR YOUR SPONSOR IN THE PERSONNEL RELIABILITY PROGRAM? YES/NO

5. ARE YOU A PREVIOUS NEW PARENT SUPPORT PROGRAM CLIENT? YES/NO

6. IF APPLICABLE, EXPECTED DUE DATE (YOU OR YOUR SPOUSE): _____

MOTHER'S SSAN	FATHER'S SSAN
FIRST TIME PARENT YES / NO	FIRST TIME PARENT YES / NO
BRANCH OF SERVICE	BRANCH OF SERVICE
MOTHER'S GRADE/RANK	FATHER'S GRADE/RANK

3. HOW DID YOU HEAR ABOUT OUR PROGRAM?

_____ NEWSPAPER/FLYER
_____ BASE TV/RADIO ANNOUNCEMENT
_____ UNIT COMMANDER/FIRST SERGEANT
_____ SUPERVISOR
_____ MEDICAL PERSONNEL
_____ FAMILY ADVOCACY PROGRAM STAFF

_____ OTHER HELPING AGENCY
(CHILD CARE CENTER,
FAMILY SUPPORT,
CHAPLAIN)
_____ FRIEND OR NEIGHBOR
_____ SPOUSE/FAMILYMEMBER
_____ OTHER

8. SPECIAL CONCERNS OR COMMENTS:

9. I understand the information in this package will be used to contact me and offer a family service plan to meet my family's needs. The information will be maintained by New Parent Support Program personnel under double lock. It may also be used by medical personnel to evaluate the quality of the New Parent Support Program.

SIGNATURE: _____

NEW PARENT SUPPORT PROGRAM

How Can We Help?

To enable the NPSP Team to best meet the needs of your family, please identify those services and areas of education listed below which you are interested in.

Pregnancy Issues

- | | |
|---|---|
| <input type="checkbox"/> Fetal growth and development | <input type="checkbox"/> Prenatal bonding |
| <input type="checkbox"/> Referral to WIC | <input type="checkbox"/> Father's role |
| <input type="checkbox"/> Nutrition | <input type="checkbox"/> Preparation for baby |
| <input type="checkbox"/> Pregnancy health issues | <input type="checkbox"/> Emotional changes |
| <input type="checkbox"/> Breast-feeding information | <input type="checkbox"/> Car seat selection |
| <input type="checkbox"/> Bottle feeding information | <input type="checkbox"/> Newborn care education |
| <input type="checkbox"/> Childbirth education | <input type="checkbox"/> Other _____ |

Childhood Issues

- | | |
|--|---|
| <input type="checkbox"/> Child development | <input type="checkbox"/> Spoiling baby |
| <input type="checkbox"/> Parenting classes | <input type="checkbox"/> Calming baby |
| <input type="checkbox"/> Safety and child proofing | <input type="checkbox"/> Sudden Infant Death (SIDS) |
| <input type="checkbox"/> Discipline | <input type="checkbox"/> Infant personality |
| <input type="checkbox"/> Infant/toddler care | <input type="checkbox"/> Sleep patterns |
| <input type="checkbox"/> Child health care issues | <input type="checkbox"/> Infant Communication |
| <input type="checkbox"/> Toy selection | <input type="checkbox"/> Temper of tantrums |
| <input type="checkbox"/> Play and activities | <input type="checkbox"/> Toilet training |
| <input type="checkbox"/> Feeding | <input type="checkbox"/> Infant massage |
| <input type="checkbox"/> Parent and child support groups | <input type="checkbox"/> Other _____ |

Family Issues

- | | |
|--|---|
| <input type="checkbox"/> Stress management | <input type="checkbox"/> Divorce |
| <input type="checkbox"/> Relationship counseling | <input type="checkbox"/> Single parenting |
| <input type="checkbox"/> Financial help | <input type="checkbox"/> Loneliness |
| <input type="checkbox"/> Self-esteem issues | <input type="checkbox"/> Past childhood experiences |
| <input type="checkbox"/> Grief issues | <input type="checkbox"/> Behavioral problems |
| <input type="checkbox"/> Sibling rivalry | <input type="checkbox"/> Other _____ |

Comments:

SIGNATURE: _____

DATE: _____

Name: _____

NPSP ID #: _____

NEW PARENT SUPPORT PROGRAM CONTACT FORM

Number of contact attempts to offer services: _____

DATE OF ATTEMPT	INITIALS OF PERSON ATTEMPTING CONTACT	TYPE OF CONTACT (PHONE OR IN-PERSON)	NOTES ON CONTACT ATTEMPS <i>(Details on SF 600, as needed)</i>

FAMILY SERVICE PLAN *(No Ongoing Home Visits*)*

FNS Total Score _____ High Needs? Yes/No

SERVICES OFFERED	YES	NO	DATE	INITIALS
OFFERED HOME VISITATION				
ACCEPTED HOME VISITATION				
COMMUNITY SERVICES OFFERED:				
Parenting Education Services ACCEPTED?				
Parent-Child Interaction Group ACCEPTED?				
Couples Communication/Problem Solving Services ACCEPTED?				
Parent Support Services ACCEPTED?				
ACCEPTED?				
ACCEPTED?				
ACCEPTED?				
ACCEPTED?				

* Family Service Plans for Participants receiving Intensive Services, including ongoing Home Visits, are documented on the Family Service Plan Form.

May we add you to our mailing list? _____ Yes _____ No

NPSP STAFF SIGNATURE: _____

Figure F-4

**FAMILY ADVOCACY INFORMED CONSENT
Prevention**

Family Advocacy prevention services are designed to strengthen and support the health and wellness of military families.

I understand that participation in the prevention program offered is completely voluntary and that I may choose to withdraw at any time without notice and without giving a reason.

I will be asked to participate in program assessment questionnaires. The data from these questionnaires will be analyzed as group data. Research findings NEVER include individual names or other identifying information.

I further understand there may be possible risks and benefits to participating. Possible risks: some questions may touch on personal or sensitive issues. Possible benefits: increased understanding of family issues and concerns, and skills in dealing with them; knowledge of health and self-care practices, and increased satisfaction with myself and other family members.

I understand that if at any time information I disclose has a bearing on my personal or my family's safety and/or medical needs, it may be necessary for you to communicate this information to a physician or appropriate Air Force personnel. In such a situation, I will be informed of the reasons for concern and the decision to relate this information.

The work of student professionals, technicians and volunteers providing services to my family is reviewed after each contact to ensure quality.

I have read this form and I fully understand benefits and risks. I agree to participate in the program.

Signature

Date

I have reviewed the information on this form with the above-identified client to ensure he/she understands FAP prevention informed consent policies.

Witness:

NPSP CASE STAFFING FORM

Initial Meeting Date: _____ NPSP ID #: _____
Participant Name: _____

Attending Team Members: _____

Family Needs Screener Total Score: _____

REFERRAL RECOMMENDATIONS

Classes: _____
Groups: _____
Health: _____
Counseling: _____
Community: _____
Primary Provider: _____
Review Date: _____

ADDITIONAL CASE STAFFING DATES:

NURSING ASSESSMENT

DATE OF ASSESSMENT: _____

1. Relevant Demographics: _____
2. Family Dynamics
 - Current relationship: _____

 - Family of origin: _____

3. Support Issues: _____
4. Depression/Self Esteem: _____
5. Stress/Violence Approval: _____
6. Substance History: _____
7. Health Background: _____
8. Nursing Diagnosis: _____
9. Discussion Notes: _____

NURSE SIGNATURE: _____

NEW PARENT SUPPORT PROGRAM DATA SUMMARY FORM

Family Name: _____	NPSP ID Number: _____
--------------------	-----------------------

Family Needs Screener *

	CATEGORY	INITIAL	6 MONTH FOLLOW-UP	6 MONTH FOLLOW-UP	CLOSURE
	DATE OF ADMINISTRATION				
	TOTAL SCORE (Items 1 through 57)				
A.	Demographics (1-13.2)				
B.	Stress (14-16;21,22)				
C.	Relationship Discord (17-20,23)				
D.	Support (24,25; 39; 45-51)				
E.	Substance Abuse (26-28)				
F.	Violence Approval (29-32)				
G.	Family-of-origin Violence and Neglect (33-38)				
H.	Self Esteem (40-44)				
I.	Depression (52-55)				
J.	Prior Family Violence (56,57)				

C. ENTRY CATEGORY:

- _____ A. Family screened as “low needs” and does not request home visits.
- B. Family screened as “low needs”, requested and received 1-2 home visits, and
1. _____ Assessed as “low needs” and referred to community services OR
2. _____ Assessed as “high needs” and refused intensive services
- _____ C. Family screened as “low needs”, requested and received home visits, assessed as “high needs” and accepted intensive services.
- _____ D. Family screened as “ high needs” but refused home visits
- _____ E. Family screened as “high needs”, accepted “home visits”, assessed as “low needs” and referred to community services
- _____ F. Family screened as “high needs”, accepted home visits, assessed as “high needs” and accepts intensive services
- _____ G. Family refused screener, but there are indications of concerns about high needs, accepted a home visit, assessed as “low needs” and referred to community services
- _____ H. Family refused screener but there are indications of high needs, accepted a home visit, assessed as “high needs” but refused intensive services

HOME VISIT MEASURES

	INITIAL	6 MONTH FOLLOW-UP	6 MONTH FOLLOW-UP	CLOSURE
DATE OF ADMINISTRATION				
CORE MEASURES⁺				
Parenting Inventory (PSI) ⁺				
Competence:				
Role Restriction:				
Attachment:				
ADDITIONAL ASSESSMENT MEASURES ⁺⁺				
Husband-Wife Conflict Scale (CTS)				
Negotiation Scale				
Psychological Aggression Scale				
Physical Assault Scale				
Parent-Child Conflict Scale (CTS-PC)				
Non-Violent Discipline Scale				
Psychological Aggression Scale				
Physical Assault Scale				
Mood Inventory (CES-D)				
Drinking Habits Inventory (S-MAST)-Self				
Summary Score:				
Quantity Frequency:				
Category:				
Drinking Habits Inventory (S-MAST)-Spouse				
Summary Score:				
Quantity Frequency:				
Category:				
Index of Marital Satisfaction (IMS)				

⁺ Required Measures

⁺⁺ Required when decision rule dictates (See NPSP Manual, Table 4G-1)

HOME Inventory ⁺

Subscale	Lowest Fourth	Middle Half	Upper Fourth	Initial	6 Month Follow-up	6 Month Follow-up	Closure
Date of Administration							
Responsivity	0-6	7-9	10-11				
Acceptance	0-4	5-6	7-8				
Organization	0-3	4-5	6				
Learning Material	0-4	5-7	8-9				
Involvement	0-2	3-4	5-6				
Variety	0-1	2-3	4-5				
Total Score	0-25	26-36	37-45				

ASQ⁺

	4 Months		6 Months		8 Months		10 Months		12 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-33.3		0-25		0-36.7		0-25		0-15.8	
Gross Motor	0-40.1		0-25		0-24.3		0-25		0-18	
Fine Motor	0-27.5		0-25		0-36.8		0-25		0-28.4	
Problems Solving	0-35		0-25		0-32.3		0-25		0-25.2	
Personal-social	0-33		0-25		0-30.5		0-25		0-20.1	

	14 Months		16 Months		18 Months		20 Months		22 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-35		0-34.5		0-35		0-36.3		0-35	
Gross Motor	0-25		0-32.3		0-25		0-36.2		0-25	
Fine Motor	0-25		0-30.6		0-25		0-39.8		0-25	
Problems Solving	0-25		0-26.9		0-25		0-29.9		0-25	
Personal-social	0-25		0-26.7		0-25		0-35.2		0-25	

	24 Months		27 Months		30 Months		33 Months		36 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-36.5		0-35		0-38.8		0-35		0-38.7	
Gross Motor	0-36		0-25		0-30.6		0-25		0-35.7	
Fine Motor	0-36.4		0-25		0-25.2		0-25		0-30.7	
Problems Solving	0-32.9		0-25		0-28.9		0-25		0-38.6	
Personal-social	0-35.6		0-25		0-36.9		0-25		0-38.7	

* Scores in this range indicate need for further evaluation

** Enter child's scores in this column

CLOSURE INFORMATION (For “C” and “F” cases only)

DATE OF CLOSURE (YYMMDD) _____

REASON: (Check One)

- | | |
|---|--|
| <input type="checkbox"/> MUTUALLY-AGREED GOALS MET | <input type="checkbox"/> NOT ELIGIBLE (Separated from Military) |
| <input type="checkbox"/> DECLINED FURTHER SERVICES | <input type="checkbox"/> SUBSTANTIATED MALTREATMENT |
| <input type="checkbox"/> ALL CHILDREN OVER 3 YEARS OLD | <input type="checkbox"/> LOSS OF CONTACT/FAILED TO |
| <input type="checkbox"/> EARLY RETURN OF DEPENDENTS | <input type="checkbox"/> KEEP APPOINTMENTS |
| <input type="checkbox"/> PCS | <input type="checkbox"/> FETAL DEMISE/INFANT or CHILD DEATH |

**NEW PARENT SUPPORT PROGRAM
FAMILY SERVICE PLAN**

Participant Name: _____ **Date:** _____

Goals	Objectives	Activities	Outcomes
1. Enhance Healthy families			
2. Increase Family Member Role Adaptation			

Goals	Objectives	Activities	Outcomes
3. Increase Problem Solving Skills			
4. Increase Knowledge of Child Growth and Development			

Date this plan will be reviewed by provider and PARTICIPANT_____

PARTICIPANT_____PROVIDER_____

HOME VISIT MEASURES

	INITIAL	6 MONTH FOLLOW-UP	6 MONTH FOLLOW-UP	CLOSURE
DATE OF ADMINISTRATION				
CORE MEASURES⁺				
Parenting Inventory (PSI) ⁺				
Competence:				
Role Restriction:				
Attachment:				
ADDITIONAL ASSESSMENT MEASURES ⁺⁺				
Husband-Wife Conflict Scale (CTS)				
Negotiation Scale				
Psychological Aggression Scale				
Physical Assault Scale				
Parent-Child Conflict Scale (CTS-PC)				
Non-Violent Discipline Scale				
Psychological Aggression Scale				
Physical Assault Scale				
Mood Inventory (CES-D)				
Drinking Habits Inventory (S-MAST)-Self				
Summary Score:				
Quantity Frequency:				
Category:				
Drinking Habits Inventory (S-MAST)-Spouse				
Summary Score:				
Quantity Frequency:				
Category:				
Index of Marital Satisfaction (IMS)				

⁺ Required Measures

⁺⁺ Required when decision rule dictates (See NPSP Manual, Table 4G-1)

HOME Inventory ⁺

Subscale	Lowest Fourth	Middle Half	Upper Fourth	Initial	6 Month Follow-up	6 Month Follow-up	Closure
Date of Administration							
Responsivity	0-6	7-9	10-11				
Acceptance	0-4	5-6	7-8				
Organization	0-3	4-5	6				
Learning Material	0-4	5-7	8-9				
Involvement	0-2	3-4	5-6				
Variety	0-1	2-3	4-5				
Total Score	0-25	26-36	37-45				

ASQ⁺

	4 Months		6 Months		8 Months		10 Months		12 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-33.3		0-25		0-36.7		0-25		0-15.8	
Gross Motor	0-40.1		0-25		0-24.3		0-25		0-18	
Fine Motor	0-27.5		0-25		0-36.8		0-25		0-28.4	
Problems Solving	0-35		0-25		0-32.3		0-25		0-25.2	
Personal-social	0-33		0-25		0-30.5		0-25		0-20.1	

	14 Months		16 Months		18 Months		20 Months		22 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-35		0-34.5		0-35		0-36.3		0-35	
Gross Motor	0-25		0-32.3		0-25		0-36.2		0-25	
Fine Motor	0-25		0-30.6		0-25		0-39.8		0-25	
Problems Solving	0-25		0-26.9		0-25		0-29.9		0-25	
Personal-social	0-25		0-26.7		0-25		0-35.2		0-25	

	24 Months		27 Months		30 Months		33 Months		36 Months	
	*	**	*	**	*	**	*	**	*	**
Date of Administration										
Communication	0-36.5		0-35		0-38.8		0-35		0-38.7	
Gross Motor	0-36		0-25		0-30.6		0-25		0-35.7	
Fine Motor	0-36.4		0-25		0-25.2		0-25		0-30.7	
Problems Solving	0-32.9		0-25		0-28.9		0-25		0-38.6	
Personal-social	0-35.6		0-25		0-36.9		0-25		0-38.7	

* Scores in this range indicate need for further evaluation

** Enter child's scores in this column

CLOSURE INFORMATION (For “C” and “F” cases only)

DATE OF CLOSURE (YYMMDD) _____

REASON: (Check One)

- | | |
|---|--|
| <input type="checkbox"/> MUTUALLY-AGREED GOALS MET | <input type="checkbox"/> NOT ELIGIBLE (Separated from Military) |
| <input type="checkbox"/> DECLINED FURTHER SERVICES | <input type="checkbox"/> SUBSTANTIATED MALTREATMENT |
| <input type="checkbox"/> ALL CHILDREN OVER 3 YEARS OLD | <input type="checkbox"/> LOSS OF CONTACT/FAILED TO |
| <input type="checkbox"/> EARLY RETURN OF DEPENDENTS | <input type="checkbox"/> KEEP APPOINTMENTS |
| <input type="checkbox"/> PCS | <input type="checkbox"/> FETAL DEMISE/INFANT or CHILD DEATH |

NEW PARENT SUPPORT PROGRAM MONTHLY REPORT

BASE: _____ MONTH: _____ YEAR: _____

NPSP GENERAL INFORMATION

Number of NPSP referrals (not birth-related) _____
Number of **Family Needs Screeners (FNS)** completed this month? _____
 Number Screened as “High Needs”? _____
 Number Accepted Home Visits? _____
 Number Screened as “Low Needs”? _____
 Number Contacted? _____
 Number Accepted Community Services? _____
 Number of Home Visits to Families Screened Low Needs? _____
Number of **HOME Inventories** completed this month? _____
Number of **PSIs (Parenting Index)** completed this month? _____
Number of **ASQs (Ages & Stages)** completed this month? _____
Number of **CES-Ds (Mood Inventory)** completed this month? _____
Number of **CTSs (Resolving Couple Conflict)** completed this month? _____
Number of **CTS-PCs (Resolving Parent-Child Conflict)** completed this month? _____
Number of **IMs (Index of Marital Satisfaction)** completed this month? _____
Number of **S-MASTs (Drinking Habits Inventory)** completed this month? _____
Number of Families with Open Maltreatment Cases Receiving Services this month? _____
Total Number of Home Visits provided by FANs _____
Total Number of Home Visits provided by FATMs _____

ENTRY CATEGORY: Enter number of new families in each category this month:

- _____ A. Families screened as “low needs” on FNS and do not request home visits.
_____ B. Families screened as “low needs” on FNS, requested and received 1-2 home visits, *and*
 1. _____ Assessed as “low needs” and referred to community services OR
 2. _____ Assessed as “high needs” and refused intensive services.
_____ C. Families screened as “low needs” on FNS, requested and received home visits, assessed as “high needs” and accepted intensive services.
_____ D. Families screened as “high needs” on FNS but refused home visits.
_____ E. Families screened as “high needs” on FNS, accepted “home visits”, assessed as “low needs” and referred to community services.
_____ F. Families screened as “high needs” on FNS, accepted home visits, assessed as “high needs” and accepted intensive services.
_____ G. Families refused screener, but there were indications of concerns about high needs, accepted an initial home visit, assessed as “low needs” and referred to community services.
_____ H. Families refused screener but there were indications of high needs, accepted an initial home visit, assessed as “high needs” but refused intensive services.

NPSP COMMUNITY REFERRALS

Number of Participants who accepted referrals for:

 Parent Education Services _____
 Parent-Child Interaction Group _____
 Couples Communication/Problem Solving Services _____
 Parent Support Services _____
 Other IDS Agency Services _____
 Civilian Community Services other than the above _____

NPSP INTENSIVE SERVICES

Number of **Open** Cases Receiving Ongoing Home Visits? _____
Number of **Active** Cases (i.e., at least one home visit during month)? _____
Number of **Active** Cases receiving home visits from FAN only? _____
Number of **Active** Cases receiving home visits from FATM only? _____
Number of **Active** Cases receiving both FAN & FATM home visits? _____

NPSP CLOSURES (Intensive Services Cases Only)

How many **Cases Closed**? _____

Of the cases closed, how many in each category below?

_____ Mutually-agreed Goals Met	_____ Not Eligible (Separated from Military)
_____ Declined Further Services	_____ Substantiated Maltreatment
_____ All Children Over 3 Years Old	_____ Loss of Contact/Failed to Keep Appointments
_____ Early Return of Dependents	_____ Fetal Demise/Infant or Child Death
_____ PCS	

OTHER FAP WORKLOAD INFORMATION:**Secondary Prevention Counseling (SPC) Services to Families AT-RISK of Maltreatment:
(Provided by FATM; See Std P-11)**

Number of referrals for SPC services this month? _____
Number of clinical assessments for SPC services conducted this month _____
Number of **Milner Questionnaires** (*Child Abuse Potential Inventory; CAP*)
completed this month? _____
Number of **CTSs** (**Resolving Couple Conflict**) completed this month? _____
Number of **CTS-PCs** (**Resolving Parent-Child Conflict**) completed
this month? _____
Number of **CES-Ds** (**Mood Inventory**) completed this month? _____
Number of **IMs** (**Index of Marital Satisfaction**) completed this month _____
Number of **S-MASTs** (**Drinking Habits Inventory**) completed
this month _____
Number of open SPC cases (**NOT NPSP**) on last day of month? _____
Number of active SPC cases (home or office visit during the month
other than class or group)? _____
Number of SPC cases closed during the month? _____

Maltreatment Workload:

Number of open maltreatment cases on last day of month? _____
Number of active maltreatment cases
(office visit during the month other than class or group)? _____
Number of NRO cases presented to FMCMT? _____
Number of Assessment Interviews with no case disposition
(referred as suspected, other than NROs)? _____

**NEW PARENT SUPPORT PROGRAM
STAFF DAILY ACTIVITY FORM**

Date: _____ Staff Name: _____ Position: (circle) FAN FATM FAOM FAPA MH Tech FAO

FILE NUMBER	PARTICIPANT NAME	SERVICE ACTIVITY	CONTACT LOCATION	PERSON CONTACTED	TRAVEL TIME	VISIT DURATION	COMMENTS

FILE NUMBER # = Open NPSP File C = Community Participant M = Maltreatment Client	SERVICE ACTIVITY PROVIDED 1=One-on-One (inc. couple, & families) 2=Support Group 3=Educational Class 4=Parent Child Group 5=Advocacy 6=Marketing	LOCATION OF CONTACT 1=In Home 2=FAP Office 3=Telephone Contact 4=MTF (Non-FAP Outpatient Clinic) 5=Hospital In-Patient 6=School, Agency, Base, Community 7=Other	WHO CONTACTED 1=Mother 2=Father of Baby/Child (FOB/C) 3=Partner-NF 4=Mother & FOB/C 5=Mother & Partner 6=Leadership, Agency, Community
--	---	--	---

Date ____/____/____

Case ID _____

U.S. Air Force Family Advocacy New Parent Support Program Family Needs Screener Scoring Sheet

Instructions for scoring the USAF Family Advocacy New Parent Support Program Family Needs Screener: Numbered items on the Family Needs Screener instrument correspond to those in the "ITEM" column below. If the person answered the questionnaire item with the responses found next to the items below, place a "1" in the "Score" column. For example, if a person answered question 1 below with either "1" (Active Duty) or "4" (Dependent Daughter), enter 1 on the same line under the "Person's Score" column. If the person answered with any other option, place a 0 in the "Score" column. For items that say "Do not score", or which were omitted by a client, then place a dash as needed. Add the 1's in the "Score" column to obtain the total needs score.

ITEM	Score
1. 1,4 = 1	
2. Do not score	
3. 1,3,4,5 = 1	
4. 2 = 1	
5. Less than 1 year=1	
6. Do not score	
7. Do not score	
8. Do not score	
9. "yes" = 1	
10. Less than 20=1	
11. Less than 20=1	
12. Do not score	
13.1 (you)1,2,3 = 1	
13.2 (partner)1,2,3 = 1	
14. 1,2 = 1	
15. 3,4 = 1	
16. 3,4 = 1	
17. 1,2 = 1	
18. 1,2 = 1	
19. 3,4 = 1	
20. 3,4 = 1	
21. 3,4 = 1	
22. 3,4 = 1 (HIGH NEED)	
23. 3,4 = 1 (HIGH NEED)	
24. 3,4 = 1	
25. 3,4 = 1	
26. 3,4 = 1	
27. 3,4 = 1	
28. 3,4 = 1	
29. 3,4 = 1	
30. 3,4 = 1	
31. 3,4 = 1	
32. 3,4 = 1	
33. 3,4 = 1	

ITEM	Score
34. 3,4 = 1	
35. 3,4 = 1	
36. 1,2 = 1	
37. 3,4 = 1	
38. 3,4 = 1	
39. 3,4 = 1	
40. 1,2 = 1	
41. 1,2 = 1	
42. 3,4 = 1	
43. 3,4 = 1	
44. 3,4 = 1	
45. 1,2 = 1	
46. 1,2 = 1	
47. 1,2 = 1	
48. 1,2 = 1	
49. 1,2 = 1	
50. 1,2 = 1	
51. 1,2 = 1	
52. 1,2 = 1	
53. 1,2 = 1	
54. 3,4 = 1 (HIGH NEED)	
55. 3,4 = 1	
56. 1=1 (HIGH NEED)	
57. 1=1 (HIGH NEED)	

TOTAL NEEDS SCORE

★ A High Needs Score is = or > 9;
OR 22, 23, 54, 56 or 57 = 1

Needs Subscales

Category	Total
A. Demographics (1-13.2)	
B. Stress (14-16;21,22)	
C. Relationship Discord(17-20,23)	
D. Support (24,25;39,45-51)	
E. Substance Abuse (26-28)	
F. Violence Approval (29-32)	

Category	Total
G. Family of origin Violence and Neglect (33-38)	
H. Self Esteem (40-44)	
I. Depression (52-55)	
J. Prior Family Violence (56,57)	

Parenting Index

This questionnaire contains 20 statements. Read each statement carefully. For each statement, please focus on the child you are most concerned about, and circle the response which best represents your opinion.

Circle the SA if you strongly agree with the statement.

Circle the A if you agree with the statement.

Circle the D if you disagree with the statement.

Circle the SD if you strongly disagree with the statement.

For example, if you sometimes enjoy going to the movies, you would circle A in response to the following statement:

I enjoy going to the movies.

SA A D SD

While you may not find a response that exactly states your feelings, please circle the response that comes closest to describing how you feel. **YOUR FIRST REACTION TO EACH QUESTION SHOULD BE YOUR ANSWER.**

Circle only one response for each statement, and respond to all statements.

-
-
1. When my child came home from the hospital, I had doubtful feelings about my ability to handle being a parent.

SA A D SD

2. Being a parent is harder than I thought it would be.

SA A D SD

3. I feel capable and on top of things when I am caring for my child.

SA A D SD

4. I can't make decisions without help.

SA A D SD

5. I have had many more problems caring for my child (children) than I expected.

SA A D SD

6. I enjoy being a parent.

SA A D SD

7. I often have the feeling that I cannot handle things very well.

SA A D SD

8. It takes a long time for parents to develop close, warm feelings for their children.

SA A D SD

9. I expected to have closer and warmer feelings for my child than I do and this bothers me.

SA A D SD

10. When I was young, I never felt comfortable holding or taking care of children.

SA A D SD

11. My child knows I am his or her parent and wants me more than other people.

SA A D SD

12. Most of my life is spent doing things for my child (infant).

SA A D SD

13. I feel trapped by my responsibilities as a parent.

SA A D SD

14. I often feel that my child's needs control my life.

SA A D SD

15. Since having this child, I have been unable to do new and different things.

SA A D SD

16. Since having a child, I feel that I am almost never able to do things that I like to do.

SA A D SD

17. It is hard to find a place in our home where I can go to be by myself.

SA A D SD

For the following statements, choose from choices 1 to 5 below.

18. When I think about myself as a parent I believe:

1. I can handle anything that happens
2. I can handle most things pretty well.
3. Sometimes I have doubts, but find that I handle most things without any problems
4. I have some doubts about being able to handle things
5. I don't think I handle things very well at all

19. I feel that I am:

1. A very good parent
2. A better than average parent
3. An average parent
4. A person who has some trouble being a parent
5. Not very good at being a parent

20. How easy is it for you to understand what your child wants or needs?

1. Very easy
2. Easy
3. Somewhat difficult
4. It is very hard
5. I usually can't figure out what the problem is

Adapted and reproduced by special permission of the Publisher, Psychological Assessment Resources, Inc., Odessa, FL 33556, from the Parenting Stress Index by Richard R. Abidin, Ed.D., Copyright 1990 by PAR, Inc.. Further reproduction is prohibited without permission from PAR, Inc.

DATE ____/____/____
BASE _____

NPSP ID#: _____

U.S.A.F. Family Advocacy New Parent Support Program Family Needs Screener

1. What is your military status? **(PLEASE CIRCLE)**

- ❶ Active Duty Member
- ❷ Family Member, Spouse
- ❸ Retired Military
- ❹ Family Member, Daughter
- ❺ Other **(SPECIFY)**: _____

2. What is the sponsor's military status? **(PLEASE CIRCLE)**

- ❶ Active Duty
- ❷ Retired Military
- ❸ Other **(SPECIFY)**: _____

3. What is your marital status? **(PLEASE CIRCLE)**

- ❶ Single
- ❷ Married
- ❸ Divorced
- ❹ Separated
- ❺ Widowed

4. What is your current living situation? Are you: **(PLEASE CIRCLE)**

- ❶ Living together with your partner/spouse
- ❷ Living alone (or with children only)
- ❸ Living with your parents (or other adults)
- ❹ Other living situation **(SPECIFY)**: _____

5. How long have you been living together: ____ Years ____ Months ____ Not Applicable

6. Are you currently pregnant or in the process of adoption? **(PLEASE CIRCLE)**

- ❶ Yes
- ❷ No **(GO TO QUESTION 7)**

(a) No. of Weeks Pregnant _____

7. Did you have or adopt a baby over the last 12 months? **(PLEASE CIRCLE)**

- ❶ Yes
- ❷ No

➡ **GO TO NEXT PAGE**

DATE ____/____/____

NPSP ID#: _____

8. How many children are living with you? (**SPECIFY**): _____

9. Do you have any children living with you who are from a prior relationship? (either yours or your partner's) (**PLEASE CIRCLE**)

① Yes

② No

10. What is your age? _____

11. What is your partner's age? _____ (**SKIP IF NOT APPLICABLE**)

Ethnic Group

12. Which of these ethnic groups do you and your partner consider yourself? (**PLEASE CIRCLE**)

1. YOU

①	Pacific Islander
②	Asian
③	Native Amer. Or Alaskan Native
④	White but not Latino
⑤	Black but not Hispanic
⑥	Latino or Hispanic
⑦	Multi-racial
⑧	Some other group (SPECIFY): _____

2. YOUR PARTNER

①	Pacific Islander
②	Asian
③	Native Amer. Or Alaskan Native
④	White but not Latino
⑤	Black but not Hispanic
⑥	Latino or Hispanic
⑦	Multi-racial
⑧	Some other group (SPECIFY): _____

Education

13. What is the last year of school that you and your partner completed? (**PLEASE CIRCLE**)

1. YOU

①	7 th Grade or Less
②	8 th Grade
③	Some High School/GED
④	High School Graduate
⑤	Some College
⑥	College Graduate
⑦	Post-B.A. Training
⑧	Advanced Degree

2. YOUR PARTNER

①	7 th Grade or Less
②	8 th Grade
③	Some High School/GED
④	High School Graduate
⑤	Some College
⑥	College Graduate
⑦	Post-B.A. Training
⑧	Advanced Degree

➔ **GO TO NEXT PAGE**

INSTRUCTIONS: FOR EACH QUESTION, PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE BEST RESPONSE

GO TO QUESTION 17 IF YOU ARE NOT CURRENTLY PREGNANT

	Strongly Disagree	Disagree	Agree	Strongly Agree
14. My partner is very supportive of this pregnancy.	1	2	3	4
15. This is an unplanned pregnancy.	1	2	3	4
16. This is not a good time for me to have a baby.	1	2	3	4

GO TO QUESTION 21 IF YOU ARE NOT CURRENTLY IN A RELATIONSHIP

17. My partner treats me well.	1	2	3	4
18. My partner and I have a very good relationship.	1	2	3	4
19. I wish my partner and I got along better.	1	2	3	4
20. I have thought seriously about ending my relationship with my partner.	1	2	3	4
21. This is a very stressful time for me.	1	2	3	4
22. At times I feel out of control, like I'm losing it.	1	2	3	4
23. Uncontrolled anger can be a problem in my family.	1	2	3	4
24. I only have a few friends/family to help with the baby (my children).	1	2	3	4
25. I feel very isolated.	1	2	3	4
26. I sometimes drink enough to feel really high or drunk.	1	2	3	4
27. I sometimes drink five or more drinks of alcohol at a time, but mostly on weekends.	1	2	3	4

GO TO QUESTION 29 IF YOU ARE NOT CURRENTLY IN A RELATIONSHIP

28. My partner sometimes drinks five or more drinks at a time, but mostly on weekends.	1	2	3	4
29. It is sometimes necessary to discipline a child with a good, hard spanking.	1	2	3	4
30. I can think of a situation when I would approve of a wife slapping a husband's face.	1	2	3	4
31. I can think of a situation when I would approve of a husband slapping a wife's face.	1	2	3	4
32. It is sometimes necessary for parents to slap a teen who talks back or is getting into trouble.	1	2	3	4
33. When I was a child I was spanked or hit a lot by my mother or father.	1	2	3	4

➔ GO TO NEXT PAGE

DATE ____/____/____

NPSP ID#: _____

INSTRUCTIONS: FOR EACH QUESTION, PLEASE READ THE FOLLOWING STATEMENTS AND CIRCLE THE BEST RESPONSE

	Strongly Disagree	Disagree	Agree	Strongly Agree
34. When I was a teenager, I was hit a lot by my mother or father.	①	②	③	④
35. When I was growing up, I saw my mother or father hit or throw something at their partner.	①	②	③	④
36. My parents helped me when I had problems.	①	②	③	④
37. I have unhappy memories of my childhood.	①	②	③	④
38. My parents did not comfort me when I was upset.	①	②	③	④
39. My income is often inadequate for basic needs (rent, food, clothing, transportation, etc.).	①	②	③	④
40. I feel that I have a number of good qualities.	①	②	③	④
41. I feel that I am a person of worth, at least on an equal basis with others.	①	②	③	④
42. I frequently feel as if I am not as good as others.	①	②	③	④
43. I feel I do not have much to be proud of.	①	②	③	④
44. All in all, I am inclined to feel that I am a failure.	①	②	③	④
45. Someone I'm close to makes me feel confident in myself.	①	②	③	④
46. There is someone I can talk to openly about anything.	①	②	③	④
47. There is someone I can talk to about problems in my relationship.	①	②	③	④
48. I have someone to borrow money from in an emergency.	①	②	③	④
49. I have someone to take care of my child/children for several hours if needed.	①	②	③	④
50. I have someone who helps me around the house.	①	②	③	④
51. I have someone I can count on in times of need.	①	②	③	④
52. I usually wake up feeling pretty good.	①	②	③	④
53. I think good things will happen to me in the future.	①	②	③	④
54. There are times when I feel life is not worth living.	①	②	③	④
55. I feel sad quite often.	①	②	③	④
	YES		NO	
56. Have you or your partner been involved in a suspected or verified case of child abuse or neglect?	①		②	
57. Have you or your partner been involved in a suspected or verified case of spouse abuse?	①		②	

END OF QUESTIONNAIRE

Page 4 of 4

THANK YOU

U.S.A.F. FAP NPSP PARENTING INDEX SCORE SHEET

Most items are scored as follows:

SA, enter a score of 5
A, enter a score of 4
D, enter a score of 2
SD, enter a score of 1

Items **3, 6, and 11** (bolded with an asterisk), are *reverse scored*, and tabulated as follows:

SA, enter a score of 1
A, enter a score of 2
D, enter a score of 4
SD, enter a score of 5

The last 3 items (**18-20**) are multiple-choice. Score by recording each of the numbers corresponding to the answer chosen (e.g., if “an average parent” is endorsed for item#19, then that item is scored “3”).

Item	Score
1.	
2.	
3.*	
4.	
5.	
6.*	
7.	
8.	
9.	
10.	

Item	Score
11.*	
12.	
13.	
14.	
15.	
16.	
17.	
18.	
19.	
20.	

PARENTING INDEX SUBSCALES

For each subscale, **SUM** the items noted:

Competence Items 1-7; 18, 19	Role Restriction Items 12-17	Attachment Items 8-11; 20
Competence TOTAL:	Role Restriction TOTAL:	Attachment TOTAL:
Cutoff Score = 21	Cutoff Score = 20	Cutoff Score = 10

NOTE: Generally, scores higher than the cut off are clinically significant.
Take into consideration possible defensiveness or need to “look good.”

NPSP ID# _____

Date ____/____/____

HOME Inventory for Families of Infants and Toddlers

Bettye M. Caldwell and Robert H. Bradley

Family Name _____ Date ____/____/____ Visitor _____

Child's Name _____ Birthdate ____/____/____ Age _____ Sex _____

Caregiver for visit _____ Relationship to child _____

Family Composition (Persons living in household, including sex and age of children)

Family Ethnicity _____ Language Spoken _____

Maternal Education _____ Paternal Education _____

Is Mother Employed? _____ Type of work when employed _____

Is Father Employed? _____ Type of work when employed _____

Address _____ Phone (____) _____

Current child care arrangements _____

Summarize past year's arrangements _____

Other persons

Caregiver for visit _____ present _____

Comments _____

SUMMARY

Subscale	Score	Percentile Range		
		Lowest Middle	Middle Half	Upper Fourth
I. Emotional and verbal RESPONSIVITY of Parent		0 – 6	7 – 9	10 - 11
II. ACCEPTANCE of Child's behavior		0 – 4	5 – 6	7 – 8
III. ORGANIZATION of Physical and Temporal Environment		0 – 3	4 – 5	6
IV. Provision of Appropriate PLAY MATERIALS		0 – 4	5 – 7	8 – 9
V. Parent INVOLVEMENT with Child		0 – 2	3 – 4	5 – 6
VI. Opportunities for VARIETY in daily stimulation		0 – 1	2 - 3	4 - 5
TOTAL SCORE		0 - 25	26 - 36	37 - 45

For rapid profiling of a family, place an X in the box that corresponds to the raw score on each subscale and the total score.

HOME Inventory for Families of Infants and Toddlers

Bettye M. Caldwell and Robert H. Bradley

Section S. **HOME INVENTORY:** Place a plus (+) or minus (-) in the box alongside each item if the behavior is observed during the visit or if the parent reports that the conditions or events are characteristic of the home environment.

I. Emotional and Verbal Responsivity

1. Parent spontaneously vocalizes to child twice.	
2. Parent responds verbally to child's verbalizations.	
3. Parent tells child name of object or person during visit.	
4. Parent's speech is distinct and audible.	
5. Parent initiates verbal exchanges with visitor.	
6. Parent converses freely and easily.	
7. Parent permits child to engage in "messy" play.	
8. Parent spontaneously praises child at least twice.	
9. Parent's voice conveys positive feelings toward child.	
10. Parent caresses or kisses child at least once.	
11. Parent responds positively to praise of child offered by visitor.	
SUBTOTAL:	

II. Acceptance of Child's Behavior

12. Parent does not shout at child.	
1. Parent does not express annoyance with or hostility to child.	
2. Parent neither slaps nor spansks child during visit.	
3. No more than one instance of physical punishment during past week.	
4. Parent does not scold or criticize child during visit.	
5. Parent does not interfere or restrict child more than 3 times.	
18. At least 10 books are present and visible.	
19. Family has a pet.	
SUBTOTAL:	

III. Organization of Environment

20. Substitute care is provided by one of three regular substitutes.	
21. Child is taken to the grocery store at least once a week.	
22. Child gets out of house at least four times/week.	
23. Child is taken regularly to doctor's office/clinic.	
24. Child has a special place for toys and treasures.	
25. Child's play environment is safe.	
SUBTOTAL:	

IV. Provision of Play Materials

26. Muscle activity toys or equipment.	
27. Push or pull toy.	
28. Stroller or walker, kiddie car, scooter, or tricycle.	
29. Parent provides toy for child during visit.	
30. Learning equipment appropriate to age – cuddly toys or role-playing toys.	
31. Learning facilitators – mobile, table and chairs, high chair, play pen.	
32. simple eye-hand coordination toys.	
33. Complex eye-hand coordination toys (those permitting combination.)	
34. Toys for literature and music.	
SUBTOTAL:	

V. Parental Involvement with Child

35. Parent keeps child in visual range, looks at often.	
36. Parent talks to child while doing household work.	
37. Parent consciously encourages developmental advances.	
38. Parent invests maturing toys with value via personal attention.	
39. Parent structures child's play periods.	
40. Parent provides toys that challenge child to develop new skills.	
SUBTOTAL:	

VI. Opportunities for Variety

41. Father provides some care daily.	
42. Parent reads stories to child at least 3 times weekly.	
43. Child eats at least one meal per day with mother and father.	
44. Family visits relatives or receives visits once a month or so.	
45. Child has 3 or more books of his/her own.	
SUBTOTAL:	

TOTAL SCORE

*for complete wording of items, refer to the Administration Manual.

THIS PAGE INTENTIONALLY LEFT BLANK

ID _____
DATE ____/____/____

Mood Inventory

Circle the number for each statement which best describes how often you felt or behaved this way –
DURING THE PAST WEEK.

	Rarely or None of the Time	Some or a Little of the Time	Occasionally or a Moderate Amount of Time	Most or All of the Time
	(Less than 1 Day)	(1-2 Days)	(3-4 Days)	(5-7 Days)
DURING THE PAST WEEK:				
1. I was bothered by things that usually don't bother me.	0	1	2	3
2. I did not feel like eating; my appetite was poor.	0	1	2	3
3. I felt that I could not shake off the blues even with help from my family or friends.	0	1	2	3
4. I felt that I was just as good as other people.	0	1	2	3
5. I had trouble keeping my mind on what I was doing	0	1	2	3
6. I felt depressed.	0	1	2	3
7. I felt that everything I did was an effort.	0	1	2	3
8. I felt hopeful about the future.	0	1	2	3
9. I thought my life had been a failure.	0	1	2	3
10. I felt fearful.	0	1	2	3
11. My sleep was restless.	0	1	2	3
12. I was happy.	0	1	2	3
13. I talked less than usual.	0	1	2	3
14. I felt lonely.	0	1	2	3
15. People were unfriendly.	0	1	2	3
16. I enjoyed life.	0	1	2	3
17. I had crying spells.	0	1	2	3
18. I felt sad.	0	1	2	3
19. I felt that people disliked me.	0	1	2	3
20. I could not get "going".	0	1	2	3

Mood Inventory Score Sheet

Step 1: Complete the score column below.

Be sure to reverse code scores for the **4 Bolded items** as follows:

If score=0, reverse code to 3

If score=1, reverse code to 2

If score=2, enter a score of 1

If score=3, enter a score of 0

<i>ITEM</i>	<i>SCORE</i>
1.	
2.	
3.	
4. Reverse code	
5.	
6.	
7.	
8. Reverse code	
9.	
10.	
11.	
12. Reverse code	
13.	
14.	
15.	
16. Reverse code	
17.	
18.	
19.	
20.	

Total =

ALWAYS RECHECK ITEM REVERSALS AND ALL COMPUTATIONS

SCORES of 16 or higher are clinically significant.

NPSP ID# _____

DATE ____/____/____

Resolving Couple Conflict Scale - SPOUSE

No matter how well a couple get along, there are times when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired for some other reason. They also use many different ways of trying to settle their differences. Below is a list of things that you and your (spouse/partner) might do when you have an argument. ***How many times in the past 12 months did YOUR PARTNER do any of these things?*** (If you answered this NPSP questionnaire before, please answer for the time period since you last filled it out, usually about six (6) months.) **PLEASE CIRCLE THE CORRECT NUMBER FOR EACH RESPONSE.**

	1=ONCE 2=TWICE 3=3-5 TIMES 4=6-10 TIMES 5=11-20 TIMES 6=MORE THAN 20 TIMES	IF NEVER IN PAST YEAR, HAS IT EVER HAPPENED?	
		Yes	No
1. Discussed an issue calmly.	1 2 3 4 5 6	Yes	No
2. Got information to back up his side of things.	1 2 3 4 5 6	Yes	No
3. Brought in, or tried to bring in, someone to help settle things.	1 2 3 4 5 6	Yes	No
4. Insulted or swore at you.	1 2 3 4 5 6	Yes	No
5. Sulked or refused to talk about an issue.	1 2 3 4 5 6	Yes	No
6. Stomped out of the room or house or yard.	1 2 3 4 5 6	Yes	No
7. Cried.	1 2 3 4 5 6	Yes	No
8. Did or said something to spite you.	1 2 3 4 5 6	Yes	No
9. Threatened to hit or throw something at you.	1 2 3 4 5 6	Yes	No
10. Threw or smashed or hit or kicked something.	1 2 3 4 5 6	Yes	No
11. Threw something at you.	1 2 3 4 5 6	Yes	No
12. Pushed, grabbed, or shoved you.	1 2 3 4 5 6	Yes	No
13. Slapped you.	1 2 3 4 5 6	Yes	No
14. Kicked, bit, or hit you with a fist.	1 2 3 4 5 6	Yes	No
15. Hit or tried to hit you with something.	1 2 3 4 5 6	Yes	No
16. Beat you up.	1 2 3 4 5 6	Yes	No
17. Choked you.	1 2 3 4 5 6	Yes	No
18. Threatened you with a knife or gun.	1 2 3 4 5 6	Yes	No
19. Used a knife or fired a gun.	1 2 3 4 5 6	Yes	No

NPSP ID# _____

DATE ____/____/____

Resolving Couple Conflict Scale - SELF

No matter how well a couple get along, there are times when they disagree, get annoyed with the other person, or just have spats or fights because they're in a bad mood or tired for some other reason. They also use many different ways of trying to settle their differences. Below is a list of things that you and your (spouse/partner) might do when you have an argument. *How many times in the past 12 months did YOU do any of these things?* (If you answered this NPSP questionnaire before, please answer for the time period since you last filled it out, usually about six (6) months.) **PLEASE CIRCLE THE CORRECT NUMBER FOR EACH RESPONSE.**

	1=ONCE 2=TWICE 3=3-5 TIMES 4=6-10 TIMES 5=11-20 TIMES 6=MORE THAN 20 TIMES	IF NEVER IN PAST YEAR, HAS IT EVER HAPPENED?	
		Yes	No
1. Discussed an issue calmly.	1 2 3 4 5 6	Yes	No
2. Got information to back up his side of things.	1 2 3 4 5 6	Yes	No
3. Brought in, or tried to bring in, someone to help settle things.	1 2 3 4 5 6	Yes	No
4. Insulted or swore at you.	1 2 3 4 5 6	Yes	No
5. Sulked or refused to talk about an issue.	1 2 3 4 5 6	Yes	No
6. Stomped out of the room or house or yard.	1 2 3 4 5 6	Yes	No
7. Cried.	1 2 3 4 5 6	Yes	No
8. Did or said something to spite you.	1 2 3 4 5 6	Yes	No
9. Threatened to hit or throw something at you.	1 2 3 4 5 6	Yes	No
10. Threw or smashed or hit or kicked something.	1 2 3 4 5 6	Yes	No
11. Threw something at you.	1 2 3 4 5 6	Yes	No
12. Pushed, grabbed, or shoved you.	1 2 3 4 5 6	Yes	No
13. Slapped you.	1 2 3 4 5 6	Yes	No
14. Kicked, bit, or hit you with a fist.	1 2 3 4 5 6	Yes	No
15. Hit or tried to hit you with something.	1 2 3 4 5 6	Yes	No
16. Beat you up.	1 2 3 4 5 6	Yes	No
17. Choked you.	1 2 3 4 5 6	Yes	No
18. Threatened you with a knife or gun.	1 2 3 4 5 6	Yes	No
19. Used a knife or fired a gun.	1 2 3 4 5 6	Yes	No

RESOLVING COUPLE CONFLICT SCALE (CTS) SCORE SHEET

Negotiation Scale:

1. Circle the answer numbers for each of the three questions and write the scores after the equal (=) sign in the column headed "score." For example, if in response to Question 3, the respondent answered "4," you would write "8" in the column headed "score" in the row for item #3.
2. Sum the 3 scores. The resulting score can range from 0 to 75.

Item #	For items marked with the first number, use = n, score in last column							score
1	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
2	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
3	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
Negotiation Total Score =								

*Scores of 3 or less indicate problem patterns in negotiating issues
and should be further evaluated.*

Psychological Aggression Scale:

1. Circle the answer numbers for each of the seven questions and write the scores after the equal (=) sign in the column headed "score."
2. Sum the 7 scores. The resulting score can range from 0 to 175.

Item #	For items marked with the first number, use = n, score in last column							score
4	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
5	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
6	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
8	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
9	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
10	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
Psychological Aggression Score =								

*Scores of 13 or more indicate possible problems with psychological
aggression and should be further evaluated.*

Physical Assault Scale:

1. Circle the answer numbers for each of the nine questions and write the scores after the equal (=) sign in the column headed "score."
2. Sum the 9 scores. The resulting score can range from 0 to 225.

Item #	For items marked with the first number, use = n, score in last column							score
11	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
12	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
13	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
14	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
15	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
16	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
17	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
18	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
19	0 or Ever=0	1=1	2=2	3=4	4=8	5=15	6=25	
Physical Assault Score =								

*Scores of 1 or more indicate possible problems with physical assault
and should be further evaluated.*

ENTER SCORES IN THE CTS SECTION OF THE DATA SUMMARY FORM

ID _____
DATE ____/____/____

Resolving Parent-Child Conflict Scale

Children often do things that are wrong, disobey, or make their parents upset or angry. We would like to know what you have done when your child did something wrong or made you upset or angry.

Below is a list of things you might have done in the past year and I would like you to tell me whether you have: done it once in the past year, done it twice in the past year, 3-5 times, 6-10 times, 11-20 times, or more than 20 times in the past year. If you haven't done it in the past year but have done it before that, I would like to know this, too.

PLEASE CIRCLE THE CORRECT NUMBER FOR EACH RESPONSE.

	1=ONCE 2=TWICE 3=3-5 TIMES 4=6-10 TIMES 5=11-20 TIMES 6=MORE THAN 20 TIMES 7=NOT IN PAST YEAR, BUT IT HAPPENED BEFORE 0=THIS HAS NEVER HAPPENED
1. Explained why something was wrong.	1 2 3 4 5 6 7 0
2. Put him/her in "time out" (or sent to his/her room)	1 2 3 4 5 6 7 0
3. Shook him/her.	1 2 3 4 5 6 7 0
4. Hit him/her on the bottom with something like a belt, hairbrush, a stick or some other hard object.	1 2 3 4 5 6 7 0
5. Gave him/her something else to do instead of what he/she was doing wrong	1 2 3 4 5 6 7 0
6. Shouted, yelled, or screamed at him/her.	1 2 3 4 5 6 7 0
7. Spanked him/her on the bottom with your bare hand.	1 2 3 4 5 6 7 0
8. Swore or cursed at him/her.	1 2 3 4 5 6 7 0
9. Slapped him/her on the hand, arm, or leg	1 2 3 4 5 6 7 0
10. Denied him/her treats or took away privileges.	1 2 3 4 5 6 7 0
11. Threatened to spank him/her but did not actually do it.	1 2 3 4 5 6 7 0
12. Pinched him/her.	1 2 3 4 5 6 7 0
13. Called him/her dumb or lazy or some other name like that.	1 2 3 4 5 6 7 0

RESOLVING PARENT-CHILD CONFLICT SCALE (CTS-PC) SCORE SHEET

Non-Violent Discipline Scale:

1. Circle the answer numbers for each of the four questions and write the scores after the equal (=) sign in the column headed "score." For example, if in response to Question 5, the respondent answered "4," you would write "8" in the column headed "score" in the row for item #5.
2. Sum the 4 scores. The resulting score can range from 0 to 100.

Item #	For items marked with the first number, use = n, score in last column							score
1	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
2	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
5	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
10	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
Non-Violent Discipline Total Score =								

Scores of 36 or less indicate difficulty with positive parenting practices.

Psychological Aggression Scale:

1. Circle the answer numbers for each of the four questions and write the scores after the equal (=) sign in the column headed "score."
2. Sum the 4 scores. The resulting score can range from 0 to 100.

Item #	For items marked with the first number, use = n, score in last column							score
6	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
8	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
11	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
13	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
Psychological Aggression Score =								

Scores of 2 or more indicate a possible failure in child management strategies and should be evaluated further.

Physical Assault Scale:

1. Circle the answer numbers for each of the five questions and write the scores after the equal (=) sign in the column headed "score."
2. Sum the 5 scores. The resulting score can range from 0 to 125.

Item #	For items marked with the first number, use = n, score in last column							score
3	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
4	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
7	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
9	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
12	0 or 7=0	1=1	2=2	3=4	4=8	5=15	6=25	
Physical Assault Score =								

Scores of 1 or more (with special concern for item #3) indicate a possible failure in child management strategies and should be evaluated further.

ENTER SCORES IN THE CTS-PC SECTION OF THE DATA SUMMARY FORM

Drinking Habits Inventory

Below is a list of questions about alcohol. Please answer all questions by circling a YES or NO response.

1. Do you feel you are a normal drinker? (By normal we mean you drink less than or as much as most other people.)
YES NO
2. Does your wife, husband, a parent, or other near relative ever worry or complain about your drinking?
YES NO
3. Do you ever feel guilty about your drinking?
YES NO
4. Do friends or relatives think you are a normal drinker?
YES NO
5. Are you able to stop drinking when you want to?
YES NO
6. Have you ever attended a meeting of Alcoholics Anonymous for a problem of your own?
YES NO
7. Has drinking ever created problems between you and your wife, husband, a parent, or other near relative?
YES NO
8. Have you ever gotten into trouble at work because of your drinking?
YES NO
9. Have you ever neglected your obligations, your family, or your work for two or more days in a row because you were drinking?
YES NO
10. Have you ever gone to anyone for help about your drinking?
YES NO
11. Have you ever been in a hospital because of drinking?
YES NO
12. Have you ever been arrested for drunken driving, driving while intoxicated, or driving under the influence of alcoholic beverages?
YES NO
13. Have you ever been arrested, even for a few hours, because of other drunken behavior?
YES NO

Drinking Habits Inventory

14. Now I'm going to ask you some questions about your use of alcohol. In the last year, how often did you drink alcohol; that is, beer, wine or liquor, on the average? Would you say:

- (1) Seven days a week
- (2) Six days a week
- (3) Five days a week
- (4) Four days a week
- (5) Three days a week
- (6) Two days a week
- (7) One day a week
- (8) One day a month
- (9) Less than 1 day a month
- (10) Never

15. When you drank alcohol in the last year, how many drinks did you usually have each day on which you drank? By a "drink," I mean a shot of hard liquor, a bottle of beer, or a 4 ounce glass of wine.

- | | |
|--------------|-------------------------------------|
| (1) 1 drink | (9) 9 drinks |
| (2) 2 drinks | (10) 10 or more drinks |
| (3) 3 drinks | (11) ½ pt. liquor |
| (4) 4 drinks | (12) 1 pt. liquor |
| (5) 5 drinks | (13) 1 5 th liquor |
| (6) 6 drinks | (14) 1 qt. Liquor |
| (7) 7 drinks | (15) Other (Specify) _____ |
| (8) 8 drinks | |

16. Is the usual pattern of drinking that you described for this past year the same or different from the way you drank before this past year?

Same Different

17. How long ago did your drinking habits change?

_____ Days/Weeks/Months/Years
(**NUMBER**) (**CIRCLE ONE**)

18. During that time when your drinking habits were different, how would you describe your drinking habits?

- (1) Non-drinker
- (2) Occasional or light social drinker
- (3) Moderate or average social drinker
- (4) Frequent or heavy social drinker
- (5) Alcoholism problem

NPSP ID# _____

DATE ____/____/____

NPSP Drinking Habits Inventory Scoring Sheet

To score: Numbered items on the Drinking Habits Inventory correspond to those in the "Item" column below. For items 1 - 13, place a "1" in the "Person's Score" column if the person answered the item with the response found next to each item below. For example, for item 1, place a "1" in the "Person's Score" column if they answered "No". Otherwise, place a dash in the "Person's Score" column. On Items 14 - 18, follow the accompanying scoring instructions.

SUMMARY SCORE

Item	Person's Score
1. No = 1	
2. Yes = 1	
3. Yes = 1	
4. No = 1	
5. No = 1	
6. Yes = 1	
7. Yes = 1	

Item	Person's Score
8. Yes = 1	
9. Yes = 1	
10. Yes = 1	
11. Yes = 1	
12. Yes = 1	
13. Yes = 1	

Summary Score _____
(Score Indicating Possible Need = 4+)

QUANTITY - FREQUENCY**QUANTITY –FREQUENCY MEASURE – ITEMS 14 & 15**

Women: 4 or more drinks per occasion AND
Frequency of at least once a week = 1 point

Men: 5 or more drinks per occasion AND
Frequency of at least once a week = 1 point

Score: 1 = Heavy drinking (either acute or chronic)
0 = Not heavy

Quantity and Frequency Score _____
(Score of 1 indicates heavy drinking)

CHANGE DRINKING HABITS**CHANGE IN DRINKING HABITS – ITEMS 16, 17 & 18**

Change in drinking habits in the recent past showing a pattern of increase may indicate a possible need for further intervention and assessment. (For example, change from a non-drinker or moderate social drinker to heavy social drinker).

Score: 0 = Pattern of DECREASE in drinking habits
1 = No significant change in drinking habits
2 = Pattern of INCREASE in drinking habits

Change in Drinking Habits Score _____

IMS

ID_____
DATE____/____/____

This questionnaire is designed to measure the degree of satisfaction you have with your present marriage. It is not a test, so there are no right or wrong answers. Answer each item as carefully and as accurately as you can by placing a number beside each one as follows:

- 1 Rarely or none of the time
- 2 A little of the time
- 3 Some of the time
- 4 A good part of the time
- 5 Most or all of the time

1. I feel that my partner is affectionate enough	
2. I feel that my partner treats me badly.	
3. I feel that my partner really cares for me.	
4. I feel that I would not choose the same partner if I had it to do over again.	
5. I feel that I can trust my partner.	
6. I feel that our relationship is breaking up.	
7. I feel that my partner doesn't understand me.	
8. I feel that our relationship is a good one.	
9. I feel that ours is a very happy relationship.	
10. I feel that our life together is dull.	
11. I feel that we have a lot of fun together.	
12. I feel that my partner doesn't confide in me.	
13. I feel that ours is a very close relationship.	
14. I feel that I cannot rely on my partner.	
15. I feel that we do not have enough interests in common.	
16. I feel that we manage arguments and disagreements very well.	
17. I feel that we do a good job of managing our finances.	
18. I feel that I should have never married my partner.	
19. I feel that my partner and I get along very well together.	
20. I feel that our relationship is very stable.	
21. I feel that my partner is a comfort to me.	
22. I feel that I no longer care for my partner.	
23. I feel that the future looks bright for our relationship.	
24. I feel that our relationship is empty.	
25. I feel there is no excitement in our relationship.	

Index of Marital Satisfaction (IMS) Score Sheet

Step 1: Complete the score column below.

Mark a "0" if item left blank or response is NOT a number between 1 and 5.

- **Note: Special scoring is needed if any items are blank or NOT numbers 1 through 5.** (E.g., participant entered a number other than 1-5, such as an "8" or maybe a "0".)

Be sure to reverse code scores for **BOLDED, *** items as follows:

If response = 1, reverse score to 5

If response = 2, reverse score to 4

If response = 3, enter a score of 3

If response = 4, reverse score to 2

If response = 5, reverse score to 1

<i>ITEM</i>	<i>RESPONSE/*SCORE</i>
1. Reverse score	*
2. Enter item response	
3. Reverse score	*
4. Enter item response	
5. Reverse score	*
6. Enter item response	
7. Enter item response	
8. Reverse score	*
9. Reverse score	*
10. Enter item response	
11. Reverse score	*
12. Enter item response	
13. Reverse score	*
14. Enter item response	
15. Enter item response	
16. Reverse score	*
17. Reverse score	*
18. Enter item response	
19. Reverse score	*
20. Reverse score	*
21. Reverse score	*
22. Enter item response	
23. Reverse score	*
24. Enter item response	
25. Enter item response	

Step 2: Add up items 1 through 25 in Score Column

Total from Step 2 _____

Step 3: Check for any items are blank or NOT numbers 1 through 5.

IF there are any, compute score as shown on page 2.

Step 4: Subtract 25 from Step 2 Total

(Total all scores – 25) _____

Participant's IMS Score:

Scoring of IMS with any items that are blank or NOT numbers 1 through 5:

1. Sum all scores (See *Response/*Score* Column, Step 2 from other side)
(#1) _____
 2. Now count the number of items completed correctly, i.e.
the item has a number entered between 1 and 5., that is
(#2) is a number less than 25, from other side = (#2) _____
 3. Then subtract the number of items completed correctly (#2) from
the Sum of all scores (#1), i.e., $(\#1) - (\#2) =$ (#3) _____
 4. Multiply the result of your subtraction in (#3) _____ by 100, i.e.,
 $(\#3) \times 100 =$ (#4) _____
 5. Multiply the Number of completed items (#2) _____ by 4, i.e.,
 $(\#2 \times 4) =$ (#5) _____
 6. Finally, take the Result of #4 and divide by the Result of #5, i.e.,
 $(\#4 / \#5) =$ (#6) = IMS adjusted score* = _____
(Enter In Participant's IMS Score box on page 1)
(*Round up to nearest whole number; 45.5=46)
-

Formula=

$$\frac{(\text{Sum} - \# \text{ complete items}) \times 100}{\# \text{ complete items} \times 4}$$

FINAL SCORES SHOULD ALWAYS RANGE FROM 0 TO 100**ALWAYS RECHECK ITEM REVERSALS AND ALL COMPUTATIONS*****SCORES OF 30 or higher are clinically significant.***